

## ABSTRACT

Title of Dissertation:       LIFTING THE VEIL ON INVISIBLE IDENTITIES: A  
                                      GROUNDED THEORY OF SELF-DISCLOSURE  
                                      FOR COLLEGE STUDENTS WITH MOOD  
                                      DISORDERS

Partamin Farzad Nawabi, Doctor of Philosophy, 2004

Dissertation Directed by:   Associate Professor, Marylu K. McEwen  
                                      Department of Counseling and Personnel Services

Little research exists about college students with mood disorders and their unique developmental issues. Previous studies of college students with disabilities have largely focused on physical and learning disabilities. In response to this gap in the current literature, this study explored how undergraduate students with mood disorders make decisions about self-disclosure while in college and the factors and influences that contribute to their decisions. This research holds the promise of increasing visibility for this hidden and otherwise invisible student population.

This qualitative inquiry, the product of a constructivist paradigm, used grounded theory methodology to develop a deeper understanding of the participants' experiences related to self-disclosure. Nine participants were identified through theoretical and purposive sampling. Each participant was enrolled in an

undergraduate program at a large, Mid-Atlantic university, and was diagnosed as having bipolar disorder or major depressive disorder by a mental health professional. Three participants were diagnosed with bipolar disorder and three with major depressive disorder. In addition to these six participants, three participants who were initially diagnosed with major depression were rediagnosed with bipolar disorder by their psychiatrists. Participants were interviewed three times during a five-month period.

The data were collected through in-depth interviewing and document analysis. Data analysis generated one core category and five key categories, which collectively formed the emergent theory that explored self-disclosure for college students with mood disorders. The core category, describing the main theme of the students' stories of self-disclosure, was Lifting the Veil. The key categories were Receiving Diagnosis, Constructing an Illness Identity, Impact of Stigma, Perceived Campus Support, and Attributes of Personality. Peer debriefers confirmed the study's credibility and an inquiry auditor substantiated the dependability of the final analysis.

The grounded theory that emerged from this research offers a framework for understanding how college students with mood disorders make decisions about self-disclosure. The findings of this study suggest important recommendations for how students, faculty, and staff may best demonstrate support for college students with mood disorders in the effort to positively influence their self-disclosure experiences as well as to promote the development of more inclusive and hospitable environments for these students.

LIFTING THE VEIL ON INVISIBLE IDENTITIES: A GROUNDED THEORY OF  
SELF-DISCLOSURE FOR COLLEGE STUDENTS WITH MOOD DISORDERS

by

Partamin Farzad Nawabi

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Advisory Committee:

Associate Professor Marylu K. McEwen, Chair  
Associate Professor Vivian S. Boyd  
Professor Francine H. Hultgren  
Dr. Sharon E. Kirkland-Gordon  
Associate Professor Susan R. Komives

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## DEDICATION



(In the name of Allah, infinitely compassionate and merciful)

My faith in God guides, nurtures, and sustains my life.

*This dissertation is dedicated to . . .*

My loving and selfless parents, who launched me on this journey and always had faith in my ability to reach my dreams.

My mother, Parwin Farzad, who, for me, defines perseverance and whose fierce determination to attain her personal and professional goals inspires me to achieve mine.

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*I carry you all in my heart.*

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# CHAPTER I

## INTRODUCTION

[Self-disclosing] means that I don't have to hide, or put up other fronts. It validates me. In a way, I feel closer to people who I've disclosed to. And it's about building trust and not having aspects of your identity that are closeted anymore.

This is the voice of Janice (a pseudonym), a participant in a pilot study (Farzad Nawabi, 2001) that served as a precursor to this research. In this passage, Janice shared what self-disclosure means to her experience as a person living with a mood disorder. Janice also shared that she selectively disclosed this dimension of her identity because she has encountered people who acted "awkward" toward her following a disclosure. She attributed this to a general lack of knowledge about mental illness. As such, Janice described self-disclosing as a "heavy idea to load on someone. You have to choose your words carefully."

Informed by the pilot study, the current study *Lifting the Veil on Invisible Identities* sought to explore and understand how nine undergraduate students, each living with a mood disorder, make decisions about self-disclosure while in college. This study focused on how students decide to balance decisions to reveal or conceal their illnesses and the factors that influence their decisions. There is much to be considered for students deciding whether or not to self-disclose their mood disorder while in college. Their perceptions of themselves and the world, as well as how and what they feel, how they behave, and how they interpret the meaning of the experience (Chickering & Reisser, 1993) influence their decisions about self-

disclosure. Additionally, consideration must also include social interactions, especially the demands imposed on an individual by society (i.e., stereotypes, labels, cultural norms, etc.). Stigma surrounding mental illness makes decisions to disclose a mood disorder threatening and problematic for students and contributes to an unwillingness to disclose (Cooper 1995, 1997). Greene (2000) contended that “people must balance competing needs to obtain benefits from disclosure yet avoid negative consequences from sharing” (p. 123).

Students who do not “fit” the majority norm along identity dimensions including race, ethnicity, gender, religion/faith, age, abilities, or sexual orientation are often marginalized (McEwen, 1996). Because mental illness deviates from normative standards of health and wellness, students with mood disorders are also marginalized and may even experience additional challenges and struggles in their growth and development in college. It is important to understand these challenges and provide students with mood disorders the necessary support and encouragement to facilitate their growth while in college.

To enhance understanding of the developmental needs of students with mood disorders, it is important for educators to understand how the college experience influences students’ decisions about self-disclosing a mood disorder. Ableism, the systematic discrimination toward people with disabilities (Rauscher & McClintock, 1997), and societal stigma toward mental illness and people with mental illnesses are present in college and university settings. Stigma and discrimination introduce additional challenges to students with mood disorders as they grow and develop in college. Through understanding how undergraduate students make decisions about

revealing a mood disorder while in college, educators may better demonstrate support for these students in the effort to positively influence their self-disclosure experiences.

### Mood Disorders Defined

Definitions of terminology used in this study are provided as a basis from which to understand the background and purpose of this research. According to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000), mental disorders include mood disorders (e.g., bipolar disorder and depression), schizophrenia, anxiety disorders, and personality disorders. For purposes of this study, mental illnesses are limited to the following mood disorders: (a) bipolar disorder and (b) major depressive disorder. These disorders were chosen as the focus of this research because they are characterized by certain common symptoms, including stress and other environmental conditions as a trigger factor, as well as a possible genetic predisposition (DSM-IV-TR, 2000; Dal Pozzo & Bernstein, 1987; Mondimore, 1999).

#### *Bipolar Disorder*

Bipolar disorder is rooted in the brain's inability to regulate mood (Mondimore, 1999). Different symptoms may arise at different times as mood states of affected persons move to two polar extremes – depression and mania (Mondimore). A diagnosis of “bipolar I” disorder is made if a person experiences one or more manic episodes or mixed episodes. Often individuals have also experienced one or more major depressive disorders (to be described in a subsequent section) (DSM-IV-TR, 2000). A diagnosis of “bipolar II” disorder is made if a



person experiences one or more major depressive episodes accompanied by at least one hypomanic episode.

A manic episode is characterized by a period of abnormally and persistently elevated, expansive, or irritable mood that lasts at least one week and is accompanied by at least three of the following symptoms (four if the mood is only irritable): inflated self-esteem or grandiosity, decreased need for sleep, pressure of speech (i.e., rapid speech that is virtually nonstop and usually hard to interrupt), flight of ideas (i.e., accelerated speech with abrupt shift in conversation from topic to topic), distractibility, increased involvement in goal directed activities, or psychomotor agitation (i.e., excessive motor activity that is usually repetitious - pacing, fidgeting, wringing of the hands, inability to sit still), and excessive involvement in pleasurable activities with a high potential for painful consequences (DSM-IV-TR, 2000).

A mixed episode is defined by a period of time in which the diagnostic criteria outlined in the DSM-IV-TR (2000) are met for both a manic episode and a depressive episode nearly every day and last for at least one week. The individual experiences alternating moods such as sadness and irritability accompanied by symptoms of a manic episode. For both manic episodes and mixed episodes, the mood disturbance must be “sufficiently severe to cause marked impairment in occupational functioning or usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features” (DSM-IV-TR, p. 362).

A hypomanic episode is marked by a distinct period of abnormally and persistently elevated, expansive, or irritable mood lasting at least four days and

accompanied by at least three symptoms characteristic of a manic episode (as previously described). Unlike manic and mixed episodes, a hypomanic episode “is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features” (DSM-IV-TR, 2000, p. 368).

The cause of bipolar disorder is not yet completely understood. Because it often runs in families, genetic factors that create a predisposition to the illness in some individuals may be involved (Dal Pozzo & Bernstein, 1987). The onset of symptoms is often triggered by stressful life events, and “the symptoms and the need for medication often start when people are in their twenties or at an even earlier age” (Mondimore, 1999, p. 225). A research study that followed 52 people with bipolar disorder for two years found that “those who relapsed during the time of the study were much more likely to have experienced some stressful event” (Mondimore, p. 225). The stressors of attending college and balancing academic, social, personal, and career goals may lead to the onset of an episode characteristic of the illness. Coping with stress, feelings of inadequacy, and low self-esteem are common among persons with bipolar disorder, and are experienced at varying degrees and times throughout the college experience (Dal Pozzo & Bernstein).

Unfortunately, there is no blood test available to detect genetic predisposition to bipolar disorder and no cure for the illness; however, it can be managed through medications and psychotherapy (Mondimore, 1999). Mondimore is optimistic about future biomedical discoveries:

Several years ago I read in a magazine article that scientists know more about outer space than they do about the human brain. Fortunately that is changing very, very rapidly. We know vastly more about brain function now than we did only a few years ago, and the pace of new discoveries is accelerating. (p. 250)

### *Major Depressive Disorder*

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000), major depressive disorder is a mood disorder that is characterized by one or more major depressive episodes occurring for at least two weeks. Symptoms of depression include persistent depressed mood, loss of interest and pleasure in activities that were once enjoyed, change in appetite or weight, physical slowing or agitation, difficulty sleeping or oversleeping, energy loss, feelings of worthlessness or excessive guilt, difficulty concentrating, and recurrent thoughts of death or suicide (DSM-IV-TR). A diagnosis of major depressive disorder or unipolar major depression is made if a person experiences four or more of these symptoms nearly every day during the same two-week period (DSM-IV-TR).

There is strong evidence that major depression is, in part, a genetic disorder (Mann & Kupfer, 1993; National Alliance for the Mentally Ill, 2002). Studies show that individuals who have parents or siblings with major depressive disorder have a 1 1/2 to three times higher risk of developing this disorder (National Alliance for the Mentally Ill). The average age of onset is 25 and stress appears to play a prominent role in triggering initial episodes. In contrast to the normal emotional experiences of sadness, loss, or passing mood states, depression is persistent and can interfere

significantly with a person's ability to function (National Alliance for the Mentally Ill).

Many people still believe that the emotional symptoms caused by depression are not real and that a person should be able to "get over it" if only he or she simply tried hard enough. Because of these inaccurate beliefs, self-disclosing and seeking treatment for depression can be particularly challenging.

### Background of the Study

Little is known or understood about how college students with mood disorders make decisions about self-disclosure. This study, *Lifting the Veil on Invisible Identities*, explored and examined how nine undergraduate students with mood disorders make decisions about self-disclosure and how they balance revelation or concealment of their illnesses. Through exploring the experiences of the participants in this study, educators can draw attention to the influences that shape decisions about self-disclosure, creating supportive and inclusive environments and developing policies, practices, and services that reflect the needs of this student population.

I chose self-disclosure as the focus of this study because it represents an important starting point for research on this student population and provides insight for how students conceptualize and understand their disability. Hearing from the students themselves informs the creation of policies and practices in higher education to provide support, validation, and inclusion to students. Exploring and understanding self-disclosure also informs future research on other topics related to the development of these students. Through this research, I want to raise awareness, knowledge, and understanding regarding mood disorders in higher education settings

and increase visibility and inclusion for this hidden and rarely addressed student population.

More efforts to raise awareness and educate the public about mental illness are needed. Through this research and through participants' narratives, student affairs practitioners and faculty can gain a deeper understanding of the experiences of these students and the issues that they face, and most importantly, use this knowledge to consider new ways in which to understand and approach this population to promote their equity and inclusion in college.

This research is driven by my commitment to raise awareness and increase knowledge about, and understanding of, mood disorders particularly with respect to college students living with these disorders. The few studies examining psychiatric disabilities in higher education have been limited to supported education, disciplinary issues, policy issues relative to academic accommodations and mandates of the Americans with Disabilities Act, and the readiness of campus counseling centers to respond to students' needs. Literature in social and behavioral science disciplines examined mental illness stigma and addressed community-based interventions and rehabilitation, but were not particular to higher education contexts. My goal in carrying out this dissertation study was to engage in research that combined my interests in both student development and mental illness related issues to broaden the scope of existing research to include sociocultural experiences and educational equity and inclusion.

There is little research developed on the experiences of college students with mood disorders and other psychiatric disabilities, particularly their decisions

regarding self-disclosure. As such, this literature review examined research in a variety of areas that were relevant to the area of investigation to assist with the generation of ideas to inform this study. An overview of the literature related to the following areas provided background for this research: (a) mental illness stigma, (b) self-disclosure, and (c) college environment.

### Mental Illness Stigma

Research on attitudes toward persons with mental illness reveals how the public conceptualizes and defines such illnesses. Much of the research details negative attitudes and images of people with mental illness held by the general public, despite public education campaigns to educate and engender acceptance (Socall & Holtgraves, 1992). People with mental illness are cast as dangerous, evil, possessed, unpredictable, bizarre, public nuisances, and sinful (Cockerham, 1989; Farina, Fisher, Getter, & Fischer, 1978). A great part of this stigma is attributable to the fear surrounding mental illness and people with mental illnesses. According to Cooper (1997),

Much of the ignorance that prevails is deeply rooted in myths which surround mental illness . . . myths which foster fear for one's safety when in the presence of someone afflicted with one of these illnesses, as well as the belief that once a person is diagnosed with a mental illness they have become less of a person. (p. 2)

The stigma of mental illness has been documented broadly for nearly half a century. Individuals with mental illness historically have been regarded by the public with scorn, pity, fear, dislike, condescension, and avoidance (Scheff, 1984). Much of

the research on the public's conceptions of mental illness relies on public opinion analyses (Corrigan & Penn, 1999; Link & Phelan, 1999; Rabkin, 1974; Wahl, 1999). Research has indicated that when people encounter any form of mental illness, they respond with fear, dislike, and aversion (Corrigan & Penn, 1999; Rabkin, 1974; Scheff, 1984; Wright, Gronfein, & Owens, 2000). Rabkin suggested that people with mental illness have been regarded with more distaste and less sympathy than virtually any other group of people with disabilities in our society.

A survey conducted in 1992 by the University of Utah Survey Research Center suggested that the public maintains serious misconceptions about mental illness, hindering public support and proper care for people with mental illness (Fraser, 1997). The results of surveys and telephone interviews conducted with 500 randomly selected individuals throughout the state of Utah indicated that respondents tended to believe that people with mental illnesses were "incurable, hopelessly disabled, dangerous, sinful, and willingly ill" (Fraser, p. 464).

Link and Cullen (1986) explored how contact (whether by choice or imposed) influences a person's perception of how dangerous people with mental illness are. The results suggested that regardless of type of contact, the more interaction people had with individuals with mental illness, the less they perceived them as dangerous, and the more likely they were to have positive feelings toward them. Link and Cullen concluded that in the absence of contact with people with mental illness, pre-existing attitudes and stereotypes from the prevailing culture would influence the public's view of them. Findings from Link and Cullen's study suggested that interventions

designed to increase contact with people who have mental illnesses can reduce fear, increase tolerance, and promote understanding.

The misconceptions and stigma surrounding mental illness often make it difficult for individuals to seek support or openly identify as a person with a mental illness (Cooper, 1995). And due to stigma and discrimination, disclosing this identity can be particularly strenuous for college students living with mood disorders. More efforts to raise awareness and educate the public about mental illness are needed. Research exploring the experiences of college students with mood disorders will increase the level of understanding about this population and the issues that they face.

### Self-Disclosure

Self-disclosure is the act of verbally sharing information about oneself, including thoughts, feelings, and experiences, to others (Derlega, Metts, Petronio, & Margulis, 1993). Psychologist Sidney Jourard initiated research on self-disclosure in 1958 in collaboration with sociologist Paul Lasakow to explore an individual's report of previous disclosures to various people in his or her life (Jourard, 1971). Jourard (1971) believed that when individuals reveal themselves completely to others, they begin to understand and value themselves, process their experiences fully, achieve healthy personalities, and "live more authentically" (p. v). Cozby (1973) defined self-disclosure as "any information about himself [or herself] which Person A communicates to Person B" (p. 73). Self-disclosure, however, is a complex process involving more than the simple transfer of information; self-disclosure allows people to "elicit emotional support from others, obey social norms, and probe others for information" (Sickmund, 1989, p. 1).



People often make active and deliberate choices about disclosing private information. Individuals are more likely to reveal personal information to others when they perceive the context or situation to be appropriate (Petronio, Martin, & Littlefield, 1984). According to Jourard (1971), the key determinants of self-disclosure are the identity of the disclosure recipient and the nature of the relationship between the discloser and the recipient. Individuals are more likely to disclose personal information to those with whom they are comfortable and perceive as trustworthy or to those who are willing to disclose similar kinds of information. People tend to “self-disclose to those who have already demonstrated that they will not punish the self-disclosure” (Goodstein & Reinecker, 1974, p. 51).

Individuals often are vulnerable and experience a risk when they decide to disclose personal information (Derlega, Metts, Petronio, & Margulis, 1993). By revealing information about ourselves, “we risk giving information that may jeopardize our relations or compromise another’s view of who we are” (Derlega et al., p. 87).

If individuals know personal information about us, they may divulge this information to people we don’t know or like; disclosers may find out that others avoid or do not like them after they talk about certain matters; individuals who disclose personal information with the notion of strengthening a close relationship may discover that the recipient of the disclosure is indifferent to the bid for intimacy or even may ridicule them. (Derlega et al., p. 66)

Decisions to reveal information about oneself depend on the degree of risk that an individual perceives (Derlega et al.). Derlega et al. suggested that disclosure likely occurs when risks are perceived to be low and when the timing is right, the discloser feels secure, and the information is relevant to the disclosure recipient. Conversely, when the risk is high, people often conceal information and avoid revealing information about themselves unless circumstances justify disclosure.

In a study of 26 college students with psychiatric disabilities exploring their experiences returning to college after a psychiatric hospitalization, Dougherty, Campana, Kontos, Flores, Lockhart, and Shaw (1996) found that students' perceptions of self and decisions to disclose their disabilities were largely influenced by a social process of becoming labeled as deviant, unacceptable, and blameworthy. Students feared being perceived as "different" on campus. Their perceptions of stigma on campus were a primary source of anxiety and concern. The students practiced "modified disclosure" in which they selectively disclosed aspects of their psychiatric history to others or chose "no disclosure" because "the risks of being open far outweigh any gains that may result from it" (Dougherty et al., p. 63). There is much at stake when disclosing a disability to others including "an individual's identity, self-esteem, and sense of autonomy" (Lynch & Gussel, 1996, p. 353). When making decisions to self-disclose, individuals must balance the needs to achieve benefits from disclosure yet avoid consequences from revealing personal information about themselves (Petronio, 2000).

Additional research is needed to raise awareness for college students with mood disorders and understand their development related to self-disclosure. The

hidden or invisible nature of psychiatric disorders makes it difficult to define, identify, and understand these disabilities (McEwen, 1996). Therefore, “it is important to learn how an individual with a disability understands and conceptualizes that disability” (McEwen, 1996, p. 205). This study illuminates the experiences of participants who are college students with mood disorders and reveals their experiences related to self-disclosure through narratives that tell their stories in their own words.

### College Environment

The college environment provides the context for this study, which explores how students make decisions about self-disclosing a mood disorder. Little is known or understood about the environment for this mostly silent, invisible population. For students with mood disorders, the college environment often is perceived as uninviting, discriminating, impersonal, and lacking support and appropriate services (Dougherty et al., 1996; Dougherty, Serebreni & Waitzman, 1995; Weiner, 1999).

Research exploring the college environment has provided deeper understanding of the impact of the environment on people, policies, and culture and how individuals influence their environments (Conyne & Clack, 1981; Hage & Aiken, 1970; Kuh, 1993; Moos, 1976; Pace & Stern, 1958; Stern, 1970; Strange, 1996a, 2000, 2003; Strange & Banning, 2001). Environmental theorists including Strange (1996a, 2003), Strange and Banning (2001), Conyne and Clack (1981), and Moos (1976) have designed models to examine and describe the college environment. Although these models inform much of our understanding about the college campus environment, they do not examine how students with mood disorders navigate

through the environment. The lack of information about how students with mood disorders experience their college environment further perpetuates their invisibility on campus and contributes to the lack of knowledge for this student population and about their experiences.

Determining the prevalence of students with mood disorders and other psychiatric illnesses in college is a complex and challenging task.

Many efforts have been made to assess the prevalence of psychiatric disorder among college students . . . These studies have produced extremely divergent results, and it is questionable whether valid inferences of a general nature can be made as to the overall prevalence of psychiatric disorder among college students. (Thompson, Bentz, & Liptkin, 1973, p. 415)

Further, most research about disabilities does not clearly define psychiatric disabilities. Studies conducted in colleges and universities indicated that students with disabilities were collectively categorized by physical, learning, chronic health, or other disabilities. The category “other” invariably included students with psychiatric disabilities, reflecting the lack of specific focus on this type of disability (Henderson, 1995; U.S. Department of Education, 1999).

The challenges associated with defining mood disorders and other psychiatric disabilities and substantiating the number of students with these disorders in college are reflected in the variance of figures reported from study to study. Percentages of students with mental disorders in higher education range from 6% to over 20% of the total student population (Dannells & Stuber, 1992; Offer & Shapiro, 1987; Rodolfa, 1987). However, Hartman (1993) asserted that most students who anonymously

disclose a disability on a survey do not necessarily identify themselves on campus as persons with a disability or request accommodations through the institution's disability support services. Hartman reported that between 1% and 3% of all students on campus identify themselves as having a disability and seek such services. Students' non-disclosure on campus makes it nearly impossible to obtain accurate and consistent figures reflecting the prevalence of students with disabilities in postsecondary education. Correspondingly, the overall presence of students with mood disorders in college remains largely unknown.

Given the lack of information about students with mood disorders in college and the stigma and negative attitudes toward this population on college campuses, this study, in its exploration of the influences that college students with mood disorders perceive to be hindering or encouraging their self-disclosure, provided critical insight into this developmental process. *Lifting the Veil on Invisible Identities* was a qualitative study which used grounded theory methodology (Glaser & Strauss, 1967; Strauss & Corbin, 1990, 1998) and a constructivist paradigm, also called the naturalistic, hermeneutic, or interpretive paradigm (Guba & Lincoln, 1989), to understand how undergraduate students with mood disorders make decisions about self-disclosure. Through the participants' narratives, educators can gain a deeper understanding of the experiences of college students with mood disorders, and these experiences reveal new ways in which to understand and approach this population.

#### Purpose of the Study

The purpose of this grounded theory study was to explore how undergraduate students with mood disorders make decisions about self-disclosure while in college.

A second purpose of the study was to categorize the data to allow an emerging theory to develop that described the factors that encouraged or inhibited a student while making decisions about self-disclosing his or her identity as a person living with a mood disorder. This research did not explain or predict the self-disclosure process; rather, it sought to explore and understand the factors that shape students' decisions about self-disclosure. This study highlighted the college experience of nine students diagnosed with bipolar disorder or major depressive disorder whose stories provided the raw data for the emerging grounded theory.

### Research Questions

This was an exploratory study using grounded theory methodology, thus it used categories and working hypotheses emerging from the data collected to arrive at findings. The data collected were interpreted in terms of the particular characteristics of the study and findings resulted from the interdependency of researcher and participant interactions (Lincoln & Guba, 1985). Further, the researcher allowed the design of the study to unfold as the research progressed, and came to understand the phenomenon through the lenses of the participants (Lincoln & Guba).

Two research questions guided the process of exploring and understanding how students make decisions about self-disclosing a mood disorder. These were:

1. How and when do college students with mood disorders decide whether or not to self disclose their identities as people with mental illnesses?
2. What critical incidents have contributed to students' decisions about self-disclosing a mood disorder while in college?

A. Stevens (1997) used similar questions in her naturalistic inquiry exploring critical incidents that contributed to lesbian identity. R. Stevens (2000) developed comparable questions in his grounded theory study exploring critical incidents in the college environment that contributed to the exploration and development of a gay identity.

After conducting initial interviews with each of the participants, the second question (listed above) was modified. The participants were challenged to identify critical incidents (i.e., significant people, places, and events) or *specific moments in time* that contributed to their decisions about self-disclosing a mood disorder while in college. During the second and third interviews, this question was further modified to ask what *influences* and *factors*, rather than what critical incidents, contributed to their decisions about self-disclosure while in college. This modification in phrasing the questions allowed participants to better recall and share their stories and reminded the researcher to use language that students can relate to and understand.

Another modification to the study included the terminology used to reference bipolar disorder and major depressive disorder. When I initiated this study, I used the term *psychiatric disability*. As the study progressed, I elected to use *mood disorders* instead. Although psychiatric disabilities include a broad range of diagnoses such as mood disorders, schizophrenia, anxiety disorders, and personality disorders, this research focused on the experiences of college students diagnosed with either bipolar disorder or major depressive disorder and did not claim to address experiences of students with other psychiatric disabilities. As such, mood disorders more precisely defines the population studied in this research.

## Researcher Assumptions

As an exploratory, descriptive study, this research sought a deep understanding of the participants' experiences related to having, experiencing, and self-disclosing a mood disorder while in college. The constructivist paradigm was appropriate for this study because of its belief that knowledge is socially constructed and can be studied by first learning what participants consider important (Guba & Lincoln, 1989). Since people with mental illness are often absent from research about them, this study was developed qualitatively so that I could truly understand and appreciate the experiences of the participants as shared through narratives in their own words.

This qualitative research design was a good match for this study for several reasons: (a) I, the researcher, was allowed to be personally connected to the study focus; (b) It allowed me to individually engage with participants and learn from their experiences; (c) It facilitated my exploration of a relatively unknown phenomenon for which there is little research and, thus, to impact related fields of study and practice with a new theory emerging from the narrative data I collected.

This research design was most appropriate for this study because I wanted to learn directly from the participants' experiences in a deep, emotive way and then tell their stories in their words. By building this research around student voices, it is my goal to inform and promote the development of policies and practices on college campuses that are reflective of the needs of this population as identified by these students themselves.



At the same time, because of the interpretive nature of qualitative research, I, as the researcher, also acknowledged “the value-laden nature of the study” (Creswell, 1998, p. 76), and was aware that my own values and biases may be present in the research. In particular, I recognized that my academic, professional, and organic knowledge of mood disorders, self-disclosure, and student development theories and experiences in college settings necessarily influenced my observations as the researcher in this study, and further, how I made meaning of and interpreted this research. I believe that my personal values and biases, as well as my organic knowledge, complemented and enhanced my understanding of the related literature.

I also assumed that the participants in this study were individuals who would offer unique experiences to the research. That is, I recognized that despite sharing the same diagnoses, each student was distinct and, therefore, experienced his or her illness differently. Thus, this research acknowledged the full range of experiences and perspectives that are reflected in each participant’s stories related to self-disclosing a mood disorder.

Finally, my own experiences as a person with a mood disorder provided me with insight and wisdom about what it means to live with this identity because it is my everyday reality. These experiences provided a dynamic lens for observation and reflection throughout this research process. Experience over time has increased my knowledge of mental illness as well as my knowledge of self, leading me to recognize that my learning and acceptance of self with respect to my illness will be a life-long process. Although I have become more comfortable with this dimension of my identity over my lifetime to date, I continue to practice modified/selective self-

disclosure, largely due to the persistence of my fear of discrimination, harassment, and stigma. Thankfully, however, the support, understanding, and encouragement I have received, and continue to receive, from family, friends, and colleagues inspire sustaining self-confidence and nurture continued self-exploration and self-development in relationship to this dimension of my persona.

### Significance of the Study

This study raises awareness for a phenomenon that remains generally unknown in the student affairs profession and will bring representation to the often silent, invisible voices and experiences of college students with mood disorders, thereby enhancing the college experiences of this courageous and remarkable student population.

Previous studies of students with disabilities in higher education have largely focused on physical and learning disabilities. Studies involving students with psychiatric disabilities have been relatively few in number. One study by Discala (1993) involved quantitative research on institutional policies and procedures regarding procedural due process at both public and private universities for college students with emotional or mental impairments. Weiner (1997) conducted a single institution qualitative study with eight college students with mental illnesses to explore the purpose and goals of their academic programs. Chaffin (1998) examined postsecondary access for individuals with psychological disabilities through an analysis of federal rulings and interviews with disability service providers, counselors, and other university personnel concerning institutional policies and practices. Megivern (2001) combined quantitative and qualitative methods to

examine patterns in mental health treatment utilization, education-related experiences, and college integration of students with mental illness.

Still, no study focusing on psychiatric disabilities has explored how college students make decisions about self-disclosing a mood disorder during their higher education journeys. Thus, this study not only identifies and examines a gap in the research bases, it holds the promise of developing new directions for practice by raising student, faculty, and staff awareness, knowledge, and understanding regarding the existence, prevalence, and impact of mood disorders in higher education settings. This study also increases visibility and inclusion for this hidden and otherwise invisible student population.

### Chapter Summary

This study explored how undergraduate college students make decisions about self-disclosing a mood disorder. The purpose of the study was to develop a grounded theory that described the participants' decision making process and the factors that influenced their decisions. This chapter established the background and purpose of this study and the assumptions guiding this research. Chapter II examines literature focusing on stigma of mental illness, self-disclosure, and college environments. Chapter III describes the inquiry paradigm, research design, and methodology used to conceptualize and design this study to explore how undergraduate students make decisions about self-disclosing a mood disorder in college. Chapter IV presents the findings and interpretations of the data analysis process. Finally, Chapter V provides implications for practice and further research and describes the relationship of the emergent theory to the research questions and to existing literature.

## CHAPTER II

### REVIEW OF RELATED LITERATURE

The literature in grounded theory research has a very specific use and purpose. Since the aim of grounded theory methodology is discovery of theory that evolves during the research process (Strauss & Corbin, 1990), the literature review is an ongoing process that evolves and progresses with the study (Glesne & Peshkin, 1992). Strauss and Corbin (1990) suggested that “there is no need to review all of the literature beforehand (as is frequently done by researchers trained in other approaches)” (p. 50) because it may constrain the researcher’s ability to discover relevant categories that emerge from the research and the relationships among them. An initial review of the literature helps to focus, guide and bound the study (Strauss & Corbin, 1998). Reviewing the literature identifies “what is known about a general area of inquiry and what is missing” (Glesne & Peshkin, 1992, p. 17) and ensures the proposed study’s contributions to the scholarship in a particular area. Examining existing theories and research can stimulate questions, provide ways of approaching and interpreting data, contribute to the generation of new concepts and “serve as background materials against which one compares findings from actual data gathered” (Strauss & Corbin, 1990, p. 48).

This review of literature informed this study by providing comparison points with which to explore and understand the experiences of the participants without constraining the generation of a grounded theory. It was not the intention of this examination of literature to find a theory or framework to work from in this study, but

instead to use existing theories or frameworks as points of reference for the narratives and experiences which emerge from this study.

A review of studies of college students with disabilities indicated research largely focused on physical and learning disabilities, with the majority of these studies quantitative in nature. An inquiry of studies related to psychiatric disabilities in higher education revealed considerably little research. Most of the findings from the small number of studies conducted in this area relied on quantitative research methods and did not reflect the voices and experiences of students with psychiatric disabilities.

Glaser (1978) suggested that researchers also review the literature on topics that are not directly related to the phenomenon being examined to assist with the generation of ideas to inform their fieldwork. Because there is little research developed on the experiences of college students with psychiatric disabilities, particularly their decisions regarding self-disclosure, this literature review examined research in a variety of areas that were relevant to the area of investigation while allowing for the discovery of a grounded theory. Glaser (1978) further suggested a literature review conducted after data collection and analysis, and after the discovery of the emergent theory could be used as comparisons with the grounded theory. This approach may generate support for the theory or indicate a need to revise and refine the theory and develop ideas for further exploration. This dissertation followed a traditional research format and presented literature to support the research prior to data collection and analysis. After the data were collected and analyzed and a theory had emerged, I returned to the literature that is subsequently reviewed in this chapter

to make connections between the new findings and previous research and provide a deeper understanding of the grounded theory. In addition, I reviewed some new research to provide added comparison points and discover a deeper understanding of the grounded theory.

This literature review first examines research on the stigma of mental illness. Next, the review explores self-disclosure. The review concludes with an examination of environmental models and studies addressing campus climate issues for students with psychiatric disabilities with attention to the concept of ableism.

### Stigma of Mental Illness

In 1986, the National Institute of Mental Health (NIMH) identified stigma as the most debilitating handicap faced by persons with mental illness. The 1999 Surgeon General's report on mental health identified stigma as a key variable in understanding the experience of people with mental disorders. "Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others" (U.S. Department of Health and Human Services, 1999, p. 454).

Scheff (1984) asserted that the label of mental illness is based on stereotypes learned through socialization. The stereotypes of mental illness and of people with mental illness are affirmed in the mass media and through social norms. Social definitions of mental illness and cultural stereotypes are conveyed through jokes, movies, television and print media (Link & Cullen, 1986). Negative images portrayed in the media contribute to and provide justification for deeply rooted fears about people with mental illness (Unger, 1990). The imagery projected by these

learned labels are negative (e.g., loony, flipped, psycho, wacko, etc.) and perpetuate the stigma associated with mental illness. Because “these images appear to be a functional part of the social order and integrated into the society’s psychological make-up” (Scheff, p. 62), eradicating these stereotypes is difficult.

The negative imagery and label of mental illness can affect a person’s life adversely. Several researchers (Granello & Wheaton, 2001; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Wahl, 1999) have shown that the debilitating effects of stigma for people with mental illness are as difficult to overcome as the illnesses themselves. People with mental illness often experience rejection, avoidance, and physical violence influenced by negative cultural meanings associated with mental illness (Wright, Gronfein, & Owens, 2000).

The general public widely endorses stigma about mental illness. According to Corrigan and Penn (1999), analyses of media portrayals of mental illness have identified three common misconceptions: “People with mental illness are homicidal maniacs who need to be feared; they have childlike perceptions of the world that should be marveled; and they are rebellious, free spirits” (p. 766). The discrimination that results from stigma has been widely documented in research (Chung, Chen, & Liu, 2001; Corrigan & Penn, 1999; Link et al., 1989; Wahl, 1999; Wright, Gronfein, & Owens, 2000). Chung et al. stated that stigma has negative consequences for people with mental illnesses resulting in decreased success in applying for housing, employment, and school admission. Corrigan and Penn reported that persons who are labeled mentally ill are less likely to be leased apartments and are more likely to have charges falsely pressed against them for violent crimes. Unger (1990) suggested that

“the most prevalent problems in serving students with a history of mental illness are the misconceptions and stigma about the illness” (p. 52), fueling beliefs that students are dangerous and will be disruptive on campus.

For many individuals with mental illness, the label is adopted, internalized, and incorporated into their self-concept (Socall & Holtgraves, 1992). Wahl (1999) indicated that “negative responses to people who have been identified as having a mental illness are seen as a major obstacle to recovery, limiting opportunities and undermining self-esteem” (p. 467). Individuals actively try to avoid the negative labels associated with mental illness through coping strategies such as secrecy and withdrawal (Link et al., 1989).

An exploration of mental illness stigma provides a context from which to understand students’ decisions to self-disclose a mood disorder while in college. The following section further examines research on the stigma of mental illness.

#### *Research on Stigma of Mental Illness*

Social scientists conduct several forms of stigma research. One type, public opinion studies, has revealed extremely negative attitudes toward mental illness (Wahl, 1999). Another type of stigma investigation uses participants’ ratings of people described in vignettes or profiles. Wahl reported that identical descriptions of behavior often received more social rejection, fear, and negative expectations when accompanied by information that the individual being described has a mental illness. A third type of stigma analysis is analog behavior study, in which participants are led to believe they are interacting with a person with a mental illness. Wahl asserted that stigma studies consistently show that revealing information about a history of mental



illness results in lost opportunities for housing, employment, and education. Further, such findings indicate that “identification as a patient leads to condescension and biased interpretation of behavior on the part of others, including mental health professionals” (Wahl, p. 467).

Wahl (1999) conducted a survey of 1301 participants who were diagnosed with a mental illness about their experiences of stigma and discrimination. Follow-up interviews were conducted by telephone with 100 randomly selected respondents. Survey results and telephone interviews revealed that participants experienced stigma from various sources including communities, families, coworkers, and mental health caregivers. The majority of responses from the interviews indicated that participants’ experiences of stigma and discrimination have led many to fear disclosure and maintain secrecy about their illness which resulted in reluctance to apply for jobs, education or to seek treatment. The respondents concealed their illness for fear that others would treat them unfavorably if they self-disclosed.

In another study, Link and Phelan (1999) used data from a vignette experiment to characterize public conceptions related to recognition of mental illness, beliefs about the causes and danger of mental illness, and desired social distance from people with mental illnesses. The 1444 respondents were randomly assigned to one of five vignette conditions. Four vignettes portrayed people with schizophrenia, major depressive disorder, alcohol dependence, and drug dependence, and the fifth depicted a “troubled person” with no clinical diagnosis. Link and Phelan found that the majority of the participants identified schizophrenia and major depression as

mental illnesses and attributed stressful experiences and biological and genetic factors as explanations for causes of mental illness.

Despite the promise in the public's recognition of mental illness and its causes, people with mental illness are still perceived as dangerous and the desire for social distance persists (Link & Phelan, 1999). Link and Phelan reported that participants' fears were dramatically heightened when the symptoms of mental illness were presented in vignettes even though there was no mention of violent behavior in the vignettes. In addition, participants indicated a strong desire for social distance. The findings showed a correlation between fear and willingness to interact suggesting that at least some part of the participants' reluctance to interact with people with mental illness is an exaggerated fear that symptoms lead to violence (Link & Phelan, 1999). Link and Phelan asserted that:

If the symptoms of mental illnesses continue to be linked to fears of violence, people with mental illnesses will be negatively affected through rejection, through a reluctance to seek professional help for fear of stigmatization, and through fear-based exclusion and avoidance by the public. (p. 20)

Attitudes about mental illness, particularly the stereotype of people with mental illness as dangerous, are influenced by an individual's familiarity with mental illness (Corrigan, Green, Lundin, Kubiak, & Penn, 2001). According to Corrigan et al., familiarity is defined as "knowledge of an experience with mental illness" ranging from "seeing a television portrayal of mental illness, to having a friend or coworker who has a mental illness, to having a family member who has a mental illness, to having a mental illness oneself" (p. 954). Research has indicated that a lack of

familiarity is associated with prejudicial attitudes about mental illness (Corrigan et al.).

Corrigan et al. (2001) examined the relationship between familiarity, social distance, and stigmatizing attitudes about mental illness. A total of 108 community college students completed three written measures about familiarity, perception of dangerousness, fear, and social distance. The researchers explored whether familiarity with mental illness diminishes one's fear of persons with mental illness as well as social distance from such persons. It was expected that participants who were more familiar with mental illness would be less likely to perceive persons with mental illness as dangerous, and to have less fear and less social distance.

Most of the research participants had experience with mental illness. More than a quarter of the respondents reported working with someone who had a mental illness and approximately a third reported having a friend with a mental illness (Corrigan et al., 2001). The researchers claimed that these figures were likely low because people with mental illness avoid disclosing their illness to protect themselves from public disapproval. The study findings showed that correlations between the perception of dangerousness and fear as well as between fear and social distance were strong. The results indicated that people who are relatively familiar with mental illness are less likely to perceive persons with mental illness as dangerous, and thus respond with less fear and less social distance. According to Corrigan et al., people who have knowledge about or experience with mental illness are less likely to stigmatize and discriminate against people with mental illness by avoiding them.

The State of Connecticut Department of Mental Health and Addiction Services promoted a program called “Disclosure” to increase understanding of mental illness (Corrigan & Penn, 1999). By disclosing the scope of mental illness in Connecticut and revealing recovery stories, the program aimed to reduce stigma and discrimination significantly. The states of New York and Illinois have expanded on this effort by creating a dialogue program between persons with mental illness and mental health care professionals to allow for exchange of perspectives about mental illness and to challenge stigmatizing attitudes (Corrigan & Penn). The following section examines research on the need for similar opportunities for contact between the general public and people with mental illness.

#### *Contact with People with Mental Illness*

Several researchers (Corrigan et al., 2001; Desforjes et al., 1991; Link & Cullen, 1986; Wahl, Briggs, & Zastowny, 1980) have documented that increasing the public’s familiarity with mental illness through personal contact decreases the stigma associated with mental illness and social distancing responses toward persons with mental illness. Link and Cullen reported that “contact has a highly significant and relatively constant association with perceptions of how dangerous people with mental illness are” and that increased contact lessens one’s fear of people with mental illness (p. 294). Attitudes toward mental illness potentially can be changed through increased opportunities for the public to become familiar with persons with mental illness (Link & Cullen).

Conversely, individuals who socially distance themselves from persons with mental illness perpetuate stigma and are likely to endorse discriminatory practices

related to housing, employment, and education attitudes (Corrigan et al., 2001). Link and Cullen (1986) asserted that because people with mental illness are often depicted as “dangerous and unpredictable, members of the public who have had little contact are thus influenced by these stereotypes and perceive the mentally ill to be relatively dangerous” p. 299). Link and Cullen’s research has shown that when members of the general public are exposed to people with mental illness, they are likely to revise stereotypical beliefs toward people with mental illness in general.

Wahl et al. (1980) found that college students who volunteer in psychiatric hospitals tend to have more “humanistic” views of mental illness than controls even prior to work with patients. As a result of their experience, they were even more accepting of patients and less likely to adhere to stereotypes about people with mental illnesses (Wahl et al., p. 3). Those who volunteer and work with patients in psychiatric hospitals had more positive views of people with mental illness, thus supporting the contact hypothesis that stigma is decreased with greater exposure to and contact with people with mental illness (Wahl et al., 1980).

Wahl (1999) argued that people with mental illness who are presumably the recipients of stigma are conspicuously absent from research on mental illness stigma. This failure to seek input from people with mental illness and include their perspectives may be due to: (a) the belief that public opinion accurately represents the experience of those with mental illness; (b) the desire to gather data through more controlled methodology; or (c) the belief that people with mental illness have impaired perceptions and cognitions and may be incapable of describing their experiences (Wahl). Wahl further suggested that:

The neglect of firsthand reports may also be simply an extension of the general neglect of consumer input in all mental health efforts, including research – a neglect that may itself be a reflection of stigma and of devaluation of those with psychiatric disorders . . . To truly understand and appreciate what stigma is and how it affects people with mental illnesses, we have to hear from the ones who face that stigma on a daily basis. They can best inform us – from their own personal experiences and in their own words – what stigma is, what it does, and how it is conveyed. (p. 468)

The lack of comprehensive research focusing on the qualitative experiences of people living with a psychiatric disorder provides little direction for institutions of higher education to understand the nature of these disabilities. In addition, the negative societal attitudes toward mental illness and people with mental illness reinforce the reluctance of students with psychiatric disabilities to self-disclose and advocate for their needs. Using a grounded theory approach, this current study explored how and when students with mood disorders make decisions about self-disclosure and the factors and influences that contribute to their decisions. By listening to these students' voices and empowering them to share their unique stories, further insights are gained about the issues and experiences that these students face in college, and how they relate to self-disclosure.

### Self-Disclosure

For over 20 years, Charmaz (1991) has conducted research exploring how people diagnosed with chronic illness create meanings of their illness and of themselves. In her book entitled *Good Days, Bad Days: The Self in Chronic Illness*

*and Time*, Charmaz (1991) shared excerpts of interviews she conducted with 55 participants with chronic illness, some of whom she spoke with over a period of five to eleven years. Although the participants were diagnosed with chronic illnesses such as cancer, diabetes, and multiple sclerosis and not a mental illness, their insights and experiences related to disclosing illness facilitate understanding for how college students make decisions about self-disclosing a mood disorder while in college.

Charmaz (1991) reported that people with chronic illness often struggle with the dilemma of “what they *should* tell and what they *need* to tell others about their illnesses” (p. 109, italics original). Disclosing illness can mean straining relationships, exposing hidden feelings and vulnerabilities, and risking loss of control and autonomy over one’s life (Charmaz, 1991). Consequently, Charmaz (1991) found that people avoid disclosing illness when they believe they risk losing status or self-esteem. Further, they fear being rejected and stigmatized for disclosing and for having an illness.

Individuals want to be known for attributes other than their illness and often will not disclose for fear that revealing their illness could impair others’ images and judgments of them (Charmaz, 1991). Charmaz (1991) reported that people with chronic illness fear the negative responses that often accompany disclosing illness, revealed through direct statements, gestures, and tone. For instance, Charmaz (1991) stated that although people initially show interest in disclosures from individuals with chronic illness, they soon become weary of conversations related to illness and begin to treat the person with chronic illness as “diminished, a malingerer, or an object of fleeting pity” (p. 117). Hence, people with chronic illness often guard against

disclosing their illness when they sense that others will in some way use the disclosure against them (Charmaz, 1991).

For people with mood disorders and other psychiatric disabilities, decisions to self-disclose their illness can be threatening and problematic. Disclosure can mean revealing discrediting and undesirable information about oneself (Schneider & Conrad, 1980). Schneider and Conrad's research on stigma and epilepsy revealed that people "maintain carefully segregated and selective strategies of managing the stigma potential of epilepsy" (p. 38). An individual's selective disclosure and concealment, or non-disclosure of epilepsy, are strategies employed to prevent others from "applying limiting and restrictive rules that disqualify one from normal social roles" (p. 39). Schneider and Conrad suggested that these strategies are informed by "a complex interaction of one's learned perceptions of stigma of epilepsy, actual 'test' experiences with others before and/or after disclosure, and the nature of the particular relationship involved" (p. 39). Explorations into the experience of epilepsy and stigma and disclosure provided dimensions with which to examine self-disclosure and psychiatric disabilities and understand the ways in which people manage information about themselves and their illnesses.

The stigma surrounding mental illness has contributed to the unwillingness to disclose mental illness. People may conceal certain information about themselves because they are ashamed or embarrassed and may conclude that "the nondisclosed information represents something negative or undesirable about themselves" (Derlega, Metts, Petronio, & Margulis, 1993, p. 95). Charmaz (1991) suggested that individuals risk losing acceptance by self-disclosing their illness and often experience



isolation, rejection, and stigma when they make known this information. People often avoid disclosing when they perceive that their illness could impair others' images and judgments of them (Charmaz, 1991).

Little research has been conducted on standards regulating normative behavior regarding what is socially acceptable to reveal about oneself to others or on the rules governing appropriate self-disclosure (Chaikin & Derlega, 1974). Chaikin and Derlega suggested that "disclosing intimate information about oneself at the wrong time or to the wrong persons may reflect inadequate socialization or maladjustment" (p. 588). Thompson and Dickey (1994) conducted a study in which 245 college students with various disabilities from 16 universities responded to a survey of self-perceived job search skills, including questions about disclosing their disability. The findings indicated that the participants were not confident in their ability to disclose their disability to an employer and reported that they were uncertain as to how, when, or where to disclose to a potential employer.

Another important consideration related to disclosure is privacy. According to Lynch and Gussel (1996), "persons with disabilities who disclose information about their disability are revealing private information about their own health and body that would ordinarily be considered private between persons who do not know each other well" (p. 353). Having control of one's own personal information impacts an individual's identity, self-esteem, and sense of autonomy (Goodstein & Reinecker, 1974). Charmaz (1991) reported that individuals with chronic illness avoid disclosure as a way of preserving "control of identity, control over information, control over emotional response, and control over one's life" (p. 110). Further, Jourard (1964)

contended that individuals conceal personal information about themselves to gain a sense of safety and avoid criticism, hurt, or rejection from others. People must often balance the need to disclose personal information about illness including how much will be disclosed and in what manner, and the need to maintain a sense of privacy and hence, control (Charmaz, 1991; Derlega et al., 1993; Lynch & Gussel, 1996).

Some researchers have criticized the literature on self-disclosure for depicting self-disclosure “as a unitary phenomenon which is manifested with unfailing regularity in all situations” (Goodstein & Reinecker, 1974, p. 71). Self-disclosure is a complex process entailing multiple dilemmas for students with mood disorders including when to disclose, how to disclose, how much to disclose, and to whom to disclose (Lynch & Gussel, 1996). Goodstein and Reinecker asserted that the process of self-disclosure is not experienced in the same manner for all people; rather, it is a function of the intersections among many variables including characteristics of the discloser and recipient, of the relationship between discloser and recipient, and of the situation.

Self-disclosure is a process unique to each individual. This study highlights the diversity of experiences and perspectives shared by each participant as they relate to influences that each student perceives as significant to his or her decisions to self-disclose a mood disorder while in college.

### College Environments

Several theories and models are useful for describing and understanding the college environment and the interaction between students and their campus (Conyne & Clack, 1981; Hage & Aiken, 1970; Kuh, 1993; Moos, 1976; Pace & Stern, 1958;

Stern, 1970; Strange, 1996a, 2003; Strange & Banning, 2001). Theories and models of the college environment facilitate knowledge of the various features of the environment, help student affairs practitioners understand how these features encourage student development, and assist professionals in designing approaches to work more effectively with students and to facilitate their growth and development (Strange, 1983, 1996a, 2003; Strange & King, 1990). An examination of the college environment provides insights for exploring how students' make decisions about self-disclosing a mood disorder while in college and guides the development of environments that reflect the needs of this student population.

Educators need to understand not only the conditions and characteristics of students with disabilities but also the conditions and characteristics of the campus environments these students inhabit. To do so requires an understanding of the various dimensions that compose any environment, as well as how these dimensions might serve institutions dedicated to educational purposes and responsive to the concerns of students with disabilities. (Strange, 2000, p. 20)

Strange (1996a, 2003) identified four dimensions of campus environments that have been widely examined in the literature: (a) physical environment, (b) human aggregate, (c) organizational structure, and (d) socially constructed environment.

Strange (1996a, 2003) described the physical environment through architectural design and structure and natural settings such as geographic location, climate, and open spaces. These physical features shape a student's first impression of an institution, influence their experiences, communicate nonverbal messages about

campus culture, and contribute to their sense of safety, security, and belonging (Strange, 2003). Features of the physical environment may support or hinder students as they make decisions regarding self-disclosing a mood disorder while in college. Words and images displayed on posters, signs, and art work and through curricular materials reflecting negative images of mental illness and people with mental illness may inhibit students from self-disclosing their identity as a person with a mood disorder and create distance and alienation for these students.

Several researchers assert that an environment's characteristics are transmitted through the collective characteristics of people in an environment, termed "human aggregates," or groups (Astin, 1993; Clark & Trow, 1966; Holland, 1973; Kolb, 1983; Myers, 1980; Strange, 1996a, 2003). Human aggregate models examine groups on campus to understand interpersonal styles and differences among students (Strange, 1996a). Astin (1962, 1968) and Astin and Holland (1961) suggested that "the dominant features of any particular environment are a reflection of the dominant characteristics of the people within it" (Strange, 1996a, p. 247). The impact dominant peer influence can have in shaping students' attitudes, values, and behaviors have been documented throughout the literature (Astin, 1993; Newcomb, 1966; Pascarella & Terenzini, 1991). Research indicates that students' perceptions of and actual experiences with stigma often inhibit their decisions to self-disclose a psychiatric disability on campus (Dougherty, et al., 1996; Weiner, 1999). This study explores influences that inhibit or encourage self-disclosure for college students with mood disabilities.

Person-environment congruence, or “fit” between people and their environment, is an essential concept in human aggregate models (Strange, 1996a). The extent to which an individual is likely to be attracted to, satisfied, productive, and stable in an environment is determined by congruent person-environment matches. This congruence is a function of how an individual perceives, constructs, and evaluates the environment (Strange, 1996a). An individual may become more satisfied and productive in a congruent person-environment match; likewise, if he or she experiences dissonance, he or she may become dissatisfied, less productive, or may even leave (Strange, 1996a). Strange (2000) suggested that “an individual placed in an incompatible environment is less likely to be reinforced for preferred behaviors, values, attitudes, and expectations, and the likelihood of that person’s leaving the environment is increased” (p. 21).

Organized environments are described through rules, policies, or curriculum in a particular setting (Hage & Aiken, 1970). Hage and Aiken’s (1970) model is useful for understanding the organization of a campus environment. They described environments along a continuum from dynamic to static. Dynamically organized environments are flexible in design, less centralized, and informal, whereas static environments are more rigid, centralized, and formal. Dynamic environments provide more flexibility, encourage creativity, and are more responsive to change. Static environments are characterized as more rigid, inflexible and less likely to be responsive to change.

Dynamic environments are often associated with successful educational experiences and provide more opportunities for involvement, creativity, and change

(Strange, 1996a, 2003). These environments characteristically appreciate individual differences, welcome participation from members of the community, encourage risk taking, and embrace interpersonal interactions (Strange, 1996a). For students with mood disorders and other psychiatric disabilities, dynamic environments can provide a space to feel accepted and welcome in a receptive and inclusive campus community.

The fourth area of environmental literature outlined by Strange (1996a, 2003) examines socially constructed environments. Models of constructed environments “reflect the subjective views or social constructions of environmental participants” (Strange, 2000, p. 22) and assume that “their perception of the environment is its reality” (Strange, 1996a, p. 256). Constructed environments address the needs-press congruency in an environment. Need is assessed by individual, self-reported behavior. Press refers to “the characteristic demands or features of the environment – as perceived by those who live in the particular environment” (Strange, 1996b, p. 1) and is further described by Strange (2000) as a consensus of individuals about what attitudes and behaviors the environment encourages and supports. Behavior in an environment is influenced by these perceptions (Strange, 2000). Pace and Stern (1958) and Stern (1970) suggested that there is a desire for need-press congruence among individuals in an environment and that congruency leads to higher satisfaction with the environment. Congruency occurs when the needs of the individual match the press of the environment (Stern).

Another theory about group construction of environments is Moos’ (1976) social ecological approach which integrates the physical and social environments to

understand the impact of the environment from the perspective of the individual. This model conceptualizes the environment into four areas: (a) organizational, (b) physical, (c) human aggregate, and (d) social climate. The social climate is composed of three dimensions: (a) relationship – communicated by the degree of involvement and the amount of support given and received in a given setting; (b) personal growth and development – reflected in areas that encourage personal development and self-enhancement; and (c) system maintenance and system change – represented by the degree to which the environment is orderly, organized, clear in its expectations, and responds to change (Moos). Moos’ model is useful for describing and understanding the personality or social climate of a given environment, which reveals the collective perceptions of people in the environment and the behaviors that are encouraged and supported in the environment.

Several theories have emerged from the study of socially constructed environments to explore the campus culture (Kuh, 1993; Kuh & Hall, 1993; Kuh, Schuh, Whitt & Associates, 1991). Strange (1996a) described the campus culture as “inherently a perceptual construct, in that it reflects the assumptions, beliefs, and values environmental inhabitants construct and use to interpret or understand the meaning of events and actions” (p. 259). The culture of college campuses is reflected in shared rules, norms, ideals and beliefs which define “the way things are done” (Strange, 1996a, p. 260) and determine what is acceptable behavior for faculty, students, and staff in campus settings (Kuh & Hall, 1993). Strange (1996a) further described the campus culture as a “critical lens through which institutional members view and evaluate their experiences” which provides “important clues for

understanding how students interact” within their campus environments (Strange, 1996a, p. 260). Perceptions and experiences of stigma, prejudice, and discrimination toward students with mood disorders are essential for understanding the culture, personality, and the values and norms of a given environment.

The essential features of an environment – its physical components and design, its human aggregate, its organizational structures, and social constructions of its presses, social climate, and culture “create a variety of environmental conditions on campus, and enhance or detract from student learning and success” (Strange, 2000, p. 22). Strange and Banning (2001) provided a model of environmental conditions and purposes for creating successful campus learning environments. Their model examines environmental conditions that (a) ensure the safety and inclusion of students in campus settings, (b) engage students and promote involvement, and (c) offer full membership in a community of learning to promote an integrated whole learning experience (Strange & Banning). Strange and Banning suggested that each of the four dimensions of campus environments (i.e., physical, human aggregate, organizational, and constructed) contribute to students’ sense of inclusion, safety, involvement, and community.

According to Strange (2000),

Colleges and universities must offer safe, secure, and inclusive environments for all students. Students who lack a basic sense of belonging in an institution, free from threat, fear, and anxiety, will likely fail at other goals of learning. (p. 23)



Strange (2000) further suggested “the need to create educational environments of ability, that is, environments capable of responding to differences” and to develop “policies, practices, and programs that secure, include, involve, and invite all students, regardless of individual differences, into the community” (p. 28). The design and creation of environments of ability enhance knowledge, sensitivity, and understanding for the issues facing students with psychiatric disabilities and encourage their learning, development, and growth.

Conyne and Clack (1981) provided another model to describe the environment. This interactive and integrative environmental design model assesses the interaction of people within three environmental contexts: (a) institutional policies and practices, (b) physical aspects, and (c) social aspects. The physical component includes natural and synthetic features in the environment. The social component consists of the demographic and personal characteristics of the people in the environment and explores their behaviors. The institutional component contains the written and unwritten policies, procedures, and rules governing the environment. The authors indicated that the three environmental components are interactive and can form intersections which they labeled physical-social, physical-institutional, and social-institutional. The ecological climate dimension evolves from an interaction among the three components and represents the collective perceptions of and reactions to all components of an environment gathered from the values, attitudes, and opinions of its members (Conyne & Clack).

Conyne and Clack (1981) asserted that “the environment shapes and is shaped by human behavior, suggesting that people are in transaction with their environment”

(p. 2). They further suggested that in order to adequately assess a particular environment, it is important to recognize the ways in which people and their environments interact. Conyne and Clack's environmental model provides context in which to explore and understand self-disclosure for students with mood disorders and the ways in which the environment shapes their decisions regarding self-disclosure and is shaped by the students themselves.

#### *Environmental Issues for Students with Mood Disorders*

As students with mood disorders navigate the campus, they must consider the impact of ableism in the college environment and its influence on their perceptions and experiences. They must evaluate environmental norms regarding values and behaviors and assess the degree to which they fit into the college environment. Perceptions, concerns, and experiences of the college campus are important considerations for understanding how students make decisions about self-disclosing a mood disorder. The following studies explored the experiences of students with psychiatric disabilities on college campuses, providing insight into campus climate issues.

Dougherty, Campana, Kontos, Flores, Lockhart, and Shaw (1996) conducted a qualitative study that explored the experiences of 26 college students with psychiatric disabilities who participated in a supported education program. Supported education programs are designed to provide social, vocational, and residential services to people with a history of multiple or long term psychiatric hospitalization to attain access to and be successful in higher education environments (Dougherty et al., 1996; Unger, 1993). The researchers sought to develop an understanding of the participants'

experiences returning to college after a psychiatric hospitalization and the issues they perceived to be most important and meaningful to them. The students agreed to participate in a series of focus groups which occurred over a five-week period. Four themes, each critical for understanding the student's school experience, emerged from this qualitative study: (a) disclosure of past psychiatric history within the social context of the school setting; (b) the variety of expectations shared by students; (c) the role of support personnel both on and off campus; and (d) the nature of support (Dougherty et al.).

Dougherty et al. (1996) reported that a significant source of anxiety and concern for students was their perceptions of stigma on campus and their fear of being labeled "mentally ill" by others. One of the most important issues facing the participants was the social dilemma created by their history with mental illness. This was a great source of anxiety as they assumed their new role on campus following hospitalization. According to Dougherty et al.,

Given the stigma of mental illness, the problem posed several questions for students to resolve: How does one portray their past on campus? How open with information should one be with other students, teachers, and administrators? What will their response be and how will it affect studies at school and relationships?

Throughout the course of the study, it was striking how consistently students stated their beliefs about being perceived as 'different' on campus. (p. 60)

A participant shared his dilemma of how open he should be with other students, faculty, and administrators about his psychiatric disability:

My whole experience at school revolved around what I can say and what I can't say [about who I am] and it makes it difficult when you have to go through a life like that . . . I felt it was like I was odd because I didn't feel comfortable in a classroom of students that were 'normal,' that was like stigma I had in my mind . . . I couldn't sit there in class because I couldn't communicate to the students or communicate to the teacher what was really on my mind.

(Dougherty et al., p. 62)

Students' apprehension of being labeled mentally ill and their perceptions of self were greatly influenced by,

A social process concerned with how people become defined by themselves and others. It is the process of becoming 'labeled.' For people with mental illness, one of the more disabling aspects of this defining and labeling process is stigma, of being labeled unacceptable, somehow blameworthy. (Dougherty et al., p. 61)

Weiner (1999) conducted a qualitative inquiry in which he explored the meaning of postsecondary education for eight college students diagnosed with various mental illnesses including bipolar disorder, depression, schizophrenia, schizoaffective disorder, and obsessive-compulsive disorder. Two central categories and one core category emerged from the grounded theory analysis. The central categories were university experience (the education recovery continuum) and the illness experience (the identity/coping continuum). The core category was termed "shifts and

variations” (to reflect the fluid association between the university experience and the illness experience) (Weiner, 1999).

The university experience category reflected students’ meaning of education including barriers to learning. Educational policies, practices, and procedures were obstacles for participants as they navigated through the college environment (Weiner, 1999). The university was described as “huge and impersonal” for a student who was “already feeling a little bit isolated and socially insecure” (Weiner, 1999, p. 406).

Weiner (1999) suggested that faculty, staff, and administrators understand how educational policies influence the process of integration into campus life for students with psychiatric disabilities.

In addition to educational barriers, the participants reported that social barriers impacted their learning and integration to college. Students’ perceptions of how others responded to them and lack of understanding and acceptance of mental illness by others affected how they felt about themselves and their ability to “self-disclose, ask for help, and take social risks” (Weiner, 1999, p. 406). Weiner (1999) indicated that “labeling and stigmatization played a key role in difficulties with self-disclosure and social isolation” (p. 406). The benefits of disclosure including receiving necessary accommodations and support services were counterbalanced with fear of being misjudged, stigmatized, and labeled (Weiner, 1999).

Little research has been conducted in higher education that explores the perceptions and experiences of students with mood disorders and other psychiatric disabilities. As a result, there is little understanding of what issues and challenges these students experience on their college campuses in relation to self-disclosure.

Research that explores the experiences of students with psychiatric disabilities within the context of college environments is crucial to understanding the development of this population. To what extent do people, places, and events in the college environment influence students' decisions about self-disclosing a mood disorder? This study focused on exploring factors both positive and negative which participants believe have significantly contributed to their decisions regarding self-disclosure while in college. Acknowledging the experiences of students with mood disorders and listening to their personal stories enhances understanding of their experiences and needs as college students.

### *Ableism*

Ableism, also referred to as handicapism, disability oppression, and disability discrimination, is the systematic discrimination and exclusion that oppresses people with disabilities (Rauscher & McClintock, 1997). Ableism describes the situation in which the non-disabled population defines norms and standards regarding health, productivity, beauty, and the value of human life which create "an environment that is often hostile to those whose physical, emotional, cognitive, or sensory abilities fall outside the scope of what is currently defined as socially acceptable" (Rauscher & McClintock, p. 198). Ableism operates at the individual, institutional, and societal/cultural levels.

At an individual level, people express prejudice toward persons with disabilities through their personal values and beliefs. Chisolm (1998) suggested that the stigma of mental illness and the misconception that it only affects the "poor, the weak, the old, and the disenfranchised" (p. B6) exist among individuals on college

campuses. The widely held belief, even among staff of mental health centers, is that “bright, young college students are protected from mental illness . . . If a major mental illness does strike a student, that person no longer fits the image of success and is quickly gotten out of sight” (Chisolm, p. B6). Influenced by prevailing myths of mental illness and unfamiliarity with this population, faculty and staff may be apprehensive about the presence of those who have mental illnesses on campus (Cooper, 1997).

Previous research has shown a lack of acceptance among faculty members of students with mental illnesses (Amada, 1985, 1986, 1996, 1997; Becker, Martin, Wajeih, Ward, & Shern, 2002). Becker et al. (2002) reported that “some faculty question the appropriateness of students with mental illnesses in their classrooms and express concerns about safety for other students, and that students will be violent or disruptive in class” (p. 360). These attitudes and beliefs indicate “a potential for stigmatizing discrimination or social distancing” (Becker et al.) which likely contribute to negative educational environments for students with mental illnesses. Lynch and Gussel (1996) suggested that without training, institutional support, and contact with persons with disabilities, faculty members are less likely to possess positive attitudes toward persons with disabilities. Advocacy efforts in addition to clinical and medical support provided by campus counseling and health centers, and education of faculty and other members of the campus community about mental illness are critical for promoting attitudinal change and creating supportive environments for students with mental illnesses.

Ableism at the cultural level is perpetuated through stereotypes, jokes, and media portrayals depicting negative images of people with disabilities (Corrigan & Penn, 1999; Wahl, 1999). Ableism prevails through “social beliefs, cultural norms, and media images about beauty, intelligence, physical ability, communication, and behavior” (Rauscher & McClintock, 1997, p. 202) and often results in the negative treatment of people with disabilities. Research on public attitudes toward people with mental illness underscores the prevalence of ableism. Studies of social distance reveal that of the four major “unacceptable” groups in society: ex-convicts, alcoholics, people with mental retardation, and people with mental illness, the latter are rated the most unacceptable (Tringo, 1970; Farina & Burns, 1984).

In addition, institutional attitudes toward students with mental illness are influenced by stereotypic views of mental illnesses and ignorance about these students’ needs and capabilities. At the institutional level, ableism limits legal protections and access to educational services and denies equity and equality for people with disabilities in postsecondary educational institutions (Becker et al., 2002; Chaffin, 1998).

Ableism invariably creates unwelcoming environments for students with mood disorders. Students may be inhibited from self-disclosing a mood disorder in environments that promote and tolerate ableism. Environments that challenge stigma and cultural norms defining mental illness as deviant and promote positive and inclusive policies and practices create spaces for students to openly disclose a mood disorder if they choose to reveal this aspect of their identities.



### *Pilot Study*

This research builds on a previous qualitative inquiry (Farzad Nawabi, 2001) which served as a pilot for this study. The pilot study aimed to explore and understand critical incidents that contributed to self-disclosure for undergraduate students diagnosed with mood disorders. Three students who were enrolled in an undergraduate program at a large, Mid-Atlantic university and diagnosed with a mood disorder participated in the exploratory study. Two participants were diagnosed with bipolar disorder and one participant was diagnosed with major depressive disorder.

Each student participated in one interview lasting 60-90 minutes to explore the nature and types of incidents that they perceived as critical in their decisions to self-disclose a mood disorder in college. Confidentiality was maintained by not identifying participants by their name to anyone verbally or in any written material. Participants were asked to choose a pseudonym for the purpose of maintaining confidentiality. A description of each participant is provided below.

Phoebe was 18 years old and identified as Caucasian with Jewish ethnic background, Jewish religious affiliation. At the time this study was conducted, she was a first-year student in Letters and Sciences and had not yet declared a major. Phoebe was formally diagnosed with bipolar disorder in March 2001, although she had struggled with mental health issues since early childhood.

Janice was 22 years old and identified as a White female, with Anglo and Irish ethnic backgrounds, no religious affiliation. At the time this study was conducted, she was a junior with a declared major in the College of Arts and Humanities. Janice

was formally diagnosed with major depressive disorder in March 2001, although she had a history of struggling with mental health issues since high school.

Gabe was 22 years old and identified as a Caucasian male with White ethnic background, no religious affiliation. At the time this study was conducted, he was a senior with a declared major in the College of Arts and Humanities. Gabe was diagnosed with bipolar disorder in 1993.

The following excerpts from the participant interviews illuminate the richness found in their voices. Phoebe described what meaning her illness brought to her life:

I think that it's a great thing at times because I think I can learn so much from it. It may deter me from doing things and it may hold me back and it may hurt me, but I'm thinking about applying to medical school and answering 'what is your biggest adversity in life?' and I could write about this bipolar and how I had to live with it through school, through friends, and just functioning in life.

Janice shared what it meant for her to disclose her depression to others:

It means that I don't have to sort of hide, you know, or put up other fronts, you know? I mean there are a lot of things that are good about me and I want people to see and notice, but sometimes I have trouble articulating or displaying because of my illness. I feel that my identity is like a flame. And I guess I'm always afraid that sometimes the flame is so small that other people aren't going to see it.

Gabe spoke about what it meant for him to disclose his illness with others:

I guess it means going out on a limb. It means I'm leaving that up to their interpretation. I don't expect them to understand, but I'm leaving it to their

discretion to deal with that information. I'm taking the chance that they won't understand and that they'll be irresponsible about the way they deal with it.

As a result of a constant comparative analysis, seven different categories of incidents emerged. These categories helped to organize the nature and type of various incidents reported. The categories included developing connections with faculty, developing connections with peers, being viewed as competent, establishing legitimacy of disability, establishing identity of self and disability, feeling isolated, and being invisible.

#### *Developing Connections with Faculty*

Participants described the incidents within this category as positive and negative interactions with faculty members. Developing connections with faculty members were incidents described as those that encouraged participants to disclose their illness to other faculty members, or left them discouraged and reluctant to disclose to other faculty members.

Janice remembered disclosing her identity as a person with depression to an instructor whom she perceived as “empathic” and “understanding” and who “listened and made me feel like I could be understood.” For Gabe, a positive interaction with a faculty member encouraged him to disclose to other instructors: “I remember him saying we really need to talk again, and I felt like there was a door open there. I guess I'm more likely now to tell a teacher that I need some kind of accommodation” (Gabe). In contrast, a negative interaction with an instructor left Phoebe feeling reluctant about disclosing her illness to other faculty members:

He was more focused on the academics and not on my disease, and I'm not sure if this is a good thing or bad thing. But I'm sure that this affected if I want to tell the rest of my teachers because I don't know what he is thinking about me now.

For each of the participants, developing connections with faculty, whether positive or negative experiences, were considered to be critical moments in their process of self-disclosing a mood disorder.

#### *Developing Connections with Peers*

Developing connections with peers, including those with mood disorders and other psychiatric disabilities and those without, were reported as a basis of support and affirmation for each participant. Connections with peers provided "support" (Phoebe), "a safe space" (Janice), and "a kind of togetherness" (Gabe) and were viewed by the participants as significant in their process of self-disclosing their mood disorders.

#### *Being Viewed as Competent*

Incidents described in this category involved participants' decisions to self-disclose to instructors and seek academic accommodations. The participants feared being labeled "less than" (Phoebe) or "incapable" (Janice) as a result of disclosing their disabilities.

Phoebe was reluctant to disclose her illness to instructors and ask for academic accommodations because she didn't want any "hand outs":

I don't want to use my disease as an excuse. I don't want people to think that I am a weak person or need people watching over me because I have this disease. I want them [instructors] to give me the grade that I deserve.

Janice shared how she typically disclosed her diagnosis to instructors via electronic mail. She carefully constructs the content and tone of her message so that she is perceived as responsible and capable. She shared that:

I would write something like, it might look like I've sort of been missing in action or flaking out, but I'm struggling and I've been going through a difficult time and I feel like I'm undermining myself in multiple areas of my life, it's not just your class. I am seeking counseling, I am going to the counseling center. Is there any way that I can meet you and we can talk about what is going on?

In each of the incidents shared, the participants didn't want to be perceived as "weak" (Phoebe) or "flaking out" (Janice). The participants also felt that being viewed as competent was a necessary step in their decisions to self-disclose.

#### *Establishing Legitimacy of Disability*

Some participants experienced incidents in which they felt they had to legitimize the seriousness of their illness when disclosing to instructors in order to be taken seriously and treated justly.

Gabe described an experience disclosing his illness to an instructor:

You can't just say, 'Well, I'm having some personal problems.' What the hell does that mean? That's not legit. That could mean anything. So for me to admit what I have, then a lot of times they take me more seriously. It's

important to disclose that kind of information even though you don't want to because they need to understand where you're coming from so they can be fair.

Janice legitimized her situation by equating depression with more commonly understood illnesses such as "diabetes or the flu." For Phoebe, her illness was not a "bad thing" and was "like having a broken leg or having diabetes." The participants were concerned that they would be dismissed as "lazy" (Phoebe) or "just making excuses" (Gabe), so legitimacy was considered to be critical for self-disclosure to occur.

#### *Establishing Identity of Self and Disability*

When recalling these incidents, the participants stated, "my illness is one part of my holistic being" (Janice), "my diagnosis does not define who I am" (Phoebe), and "I'm not my illness" (Gabe). Gabe shared moments when he has been reluctant to disclose his illness to peers because his identity might be equated with his illness. He stated that: "My whole being is not based around my illness. I don't want people to identify me by my illness. So, it's a tricky thing when to divulge and when not to." For each participant, establishing an identity apart from their illness was a critical step in their decisions to self-disclose a mood disorder.

#### *Feeling Isolated*

The participants shared incidents in which they felt they had to "mask" (Phoebe) or "hide" (Janice) their illness from others which intensified their feelings of isolation on campus.

Janice shared how her participation in a story circle discussion group for students with psychiatric disabilities on campus encouraged her not to hide her illness from others and helped her become more open about her disability:

Prior to my participation in story circle, I was very closeted about my depression and felt alone. I was afraid that if people knew about my illness they would see me as damaged or crazy. I was able to recognize that hiding my illness from the people in my life was a tremendous burden and was causing me additional pain instead of protecting me.

For Phoebe, not disclosing her illness to members of the sorority in which she belonged resulted in feelings of loneliness and isolation. She stated that:

I feel so distant and isolated, you know? I want to tell people, but it doesn't feel right yet. I want to curl up in a ball. Sometimes, I just want to stay in bed. It's weird. I'm not ready to tell them, but I'm tired of masking my symptoms and being alone and going through this all by myself.

Gabe discussed an incident in which he wanted to disclose his illness to one of his classmates, but chose not to because he believed he would become further "alienated from the rest of the population on campus." He shared:

I don't live in the same world as most people. People with this illness see the world differently. It is difficult to have bipolar and to feel meshed with the rest of the population anywhere, especially on a campus of young, healthy people. I guess people don't know much about mental illness or they don't want to know. Either way, it sucks for me because I go further into myself and then I don't want to interact with anyone.

Thus, for the participants, feelings of isolation on campus were critical moments in their decisions about self-disclosure on campus.

### *Being Invisible*

Incidents within this category centered on the “hidden” or “invisible” nature of mood disorders. Phoebe talked about her involvement in a sorority on campus and how she struggled to keep her identity as a person with a mood disorder a “secret part of herself.” Janice recalled how she felt “relieved” after having a conversation with a friend to whom she disclosed her illness. She said, “until then, I didn’t feel like myself. I was non-existent, invisible.” Gabe shared that he often kept his illness “hidden” from anyone but family and close friends because “I know people can’t handle it.” These incidents were significant experiences in the students’ process of disclosing a mood disorder on campus.

Organizing the critical incidents into these seven separate categories provided a basis for understanding how the incidents contributed to self-disclosure for college students with mood disorders. The participants perceived the incidents as both positive and negative. The incidents were directly and indirectly related to the participants’ decisions about self-disclosing a mood disorder. From these experiences, the participants learned how, when, and to whom to disclose their illness as they navigated through the campus environment.

Research that explores perceptions of campus climate is critical to understanding the college experiences of students with mood disorders. Little is known about perceptions, concerns, and experiences of these students on college campuses. Information about how these students interpret and make meaning of the



messages they receive about mood disorders can be used to prompt student affairs practitioners and faculty to develop programs and policies designed to meet the needs of this population.

### Chapter Summary

A review of the literature on self-disclosure, stigma, and college environments reveals that much of the research broadly explores mental illness in the general public and has rarely focused on the experiences of college students with mood disorders and other psychiatric disabilities. Research on students with disabilities in higher education has generally focused on physical and/or learning disabilities, failing to consider the experiences of students with psychiatric disabilities, the often silent and otherwise invisible illnesses that carry heavy stigmas for students attempting to succeed both academically and socially in college. Perhaps this lack of research focusing on college students with psychiatric disabilities is a reflection of the stigma and negative assumptions about people with mental illness, or the perception that psychiatric disabilities are purely clinical and medical concerns to be addressed exclusively by campus counseling and mental health centers, and not related to educational equity and inclusion or sociocultural experiences. In addition, previous research on psychiatric disabilities and higher education has largely used a quantitative mode of inquiry, neglecting the perspectives and voices of students with psychiatric disabilities. This grounded theory study fills a need in student affairs that is long overdue.

An exploration of students' voices and experiences related to having and self-disclosing a mood disorder in college is crucial to the ability of institutions of higher

education to provide support, validation, and educational equity to all students. In response to this gap in the current literature, this study illuminated this phenomenon of mental illness self-disclosure for college students by including student voices in the research, informing and promoting the development of policies and practices on college campuses that reflect the needs of this population as identified by the students themselves.

This chapter provided the organizing literature informing this study which explored influences that contributed to students' decisions about self-disclosing a mood disorder while in college. The literature review provided a framework from which to demonstrate the need for this study and identify what is known and what is lacking in existing research in this area.

## CHAPTER III

### METHODOLOGY

This chapter describes the mode of inquiry, inquiry paradigm, methodology, procedures, and data analysis used to conceptualize and design this research. The chapter is organized into the following sections: (a) research questions and research design; (b) qualitative research and the assumptions of constructivist inquiry; (c) grounded theory methodology; (d) description of participants and sources of data; (e) procedures; and (f) data analysis. The chapter concludes with considerations for establishing integrity and trustworthiness in qualitative research.

#### Research Questions and Design

This research explored and described how undergraduate college students living with a mood disorder make decisions about self-disclosure. The following questions guided this study:

1. How and when do college students with mood disorders decide whether or not to self disclose their identities as people with mental illnesses?
2. What influences and factors have contributed to students' decisions about self-disclosing a mood disorder while in college?

Since “the research question determines the focus and scope of the study” (Denzin & Lincoln, 1998, p. 67), the inquiry paradigm, methodology, and corresponding methods were carefully selected from the research questions being asked. Research questions were designed to provide initial direction and to allow flexibility to explore additional questions that may emerge and evolve throughout the course of the study (Creswell, 1998; Strauss & Corbin, 1998).

The purposes of this study were exploratory and descriptive rather than explanatory and predictive (Marshall & Rossman, 1995). Correspondingly, this was a qualitative inquiry, the product of a constructivist paradigm using grounded theory methodology to develop a deeper understanding of the participants' experiences related to self-disclosure. A total of three interviews were conducted with each of the nine participants selected for this study to explore the influences and factors which contributed to their decisions about self-disclosing a mood disorder while in college. Criteria of this study required that each participant be a current undergraduate college student and diagnosed with bipolar disorder or major depressive disorder by a mental health professional.

### Qualitative Research

Creswell (1998) defined qualitative research as:

an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting. (p. 15)

Qualitative researchers explore and interpret phenomena in relation to the meanings people assign to them (Denzin & Lincoln, 1998).

A qualitative inquiry is particularly well suited for research that is “exploratory or descriptive, that assumes the value of context and setting, and that searches for a deeper understanding of the participants' lived experiences of the phenomenon” (Marshall & Rossman, 1995, p. 39). A qualitative approach emphasizes the “researcher's role as an *active learner* who can tell the story from the

participants' view" (Creswell, 1998, p. 18, italics original) which allows their voices to "speak and carry the story through dialogue" (p. 20). Qualitative research is useful for exploring topics about which little is known (Stern, 1980; Strauss & Corbin, 1998) and for examining areas in which "variables cannot be easily identified, theories are not available to explain behavior of participants or the population of study, and theories need to be developed" (Creswell, p. 17).

Little is known about the influences and factors which contribute to decisions about self-disclosing a mood disorder for college students, and much remains to be discovered. This study employed a qualitative mode of inquiry which was particularly useful for exploring and describing the experiences of college students with mood disorders.

#### *Philosophical Assumptions Guiding Qualitative Inquiry*

Creswell (1998) recommended framing a research study within the philosophical and theoretical perspectives that guide the design of qualitative studies. The following section explores five philosophical assumptions that guide qualitative research: (a) ontological, (b) epistemological, (c) axiological, (d) rhetorical, and (e) methodological.

The ontological assumption focuses on the nature of reality (Creswell, 1998). The qualitative researcher believes that the individuals involved in the research study construct this meaning and that "multiple realities exist" (Creswell, p. 76). In this study, nine participants were interviewed to capture a range of experiences and perspectives related to self-disclosing a mood disorder. The voices and

interpretations of the research participants in this study are reported through quotes and themes that reflect the words they used.

The epistemological assumption considers the relationship between the researcher and those being researched (Creswell, 1998). The qualitative researcher interacts with the research participants to better understand their experiences of the phenomenon being studied. The researcher is recognized as the primary data-gathering source, acknowledging the experiences and perspectives of the researcher as valuable and meaningful to the study (Lincoln & Guba, 1985). The study of phenomena occurs within their natural setting, which allows for fuller understanding of the research interaction (Lincoln & Guba). My interactions with the participants occurred through interviews that were conducted within the context of the participants' college campus. As the human instrument, I processed and interpreted data and clarified meaning with the help of the participants, which enhanced the richness and depth of understanding of the phenomenon and ensured that their voices were heard throughout the process.

The axiological assumption regards the role of values in a study (Creswell, 1998). The qualitative researcher recognizes "the value-laden nature of the study and actively reports his or her values and biases as well as the value-laden nature of information gathered from the field" (Creswell, p. 76). I actively examined my values and biases throughout the process of this study. It is important to consider that I brought knowledge and experience about mood disorders to my role as the researcher in this study. I also came to this study with experience as an educator, advisor, advocate, and ally to college students. In these various roles, I have listened

with enthusiasm and appreciation to the experiences of students with mood disorders and utilized student development theory to inform and guide my interactions with them. Researcher assumptions are presented in Chapter I.

The rhetorical assumption refers to the language used in research (Creswell, 1998). “The language of qualitative studies becomes personal, literary, and based on definitions that evolve during a study rather than being defined by the researcher at the beginning of the study” (Creswell, p. 77). This study used a narrative style to illuminate the research participants’ voices and describe their experiences with respect to self-disclosure.

The methodological assumption is concerned with “how one conceptualizes the entire research process” (Creswell, 1998, p. 77). Qualitative researchers typically begin working inductively, constructing themes or working hypotheses from the actual words of the informants that emerge from the research. This process involves an emergent design in which the researcher allows the design of the study to unfold as the research progresses and not prior to the study “because it is inconceivable that enough could be known ahead of time about the many multiple realities to devise the design adequately” (Lincoln & Guba, 1985, p. 41). This study employed Lincoln and Guba’s method of inductive data analysis and allowed for an emergent design.

In addition to philosophical assumptions, ideological perspectives such as postmodernism, critical theory, or a feminist approach may be used to guide research that is particularly focused on raising awareness for the needs of people who are marginalized and promoting social action (Creswell, 1998). Constructivist inquiry, also called the naturalistic, hermeneutic, or interpretive paradigm (Guba & Lincoln,

1989) guided this study. The following section further explores and defines this research paradigm.

### *Constructivist Paradigm*

A paradigm is “a basic set of beliefs, a set of assumptions we are willing to make, which serve as touchstones in guiding our activities” (Guba & Lincoln, 1989, p. 80). A constructivist paradigm was chosen to guide this study because it “provides the best ‘fit’ whenever it is human inquiry that is being considered” (Guba & Lincoln, p. 82). Embedded in this paradigm is the belief that individuals do not find or discover knowledge – it is socially constructed in relation to shared understandings, practices, and language (Schwandt, 2000). Jones (1996a) identified social constructivism as a theoretical framework for understanding students with disabilities. Social constructivism emerges from an understanding that “much of what is believed about disability results from meanings attached by those who are not disabled and challenges the assumptions upon which those meanings rest” (p. 350).

Constructivists study the meaning a phenomenon has for the individual experiencing it by developing concepts, models, and schemes to make sense of the experience and continually testing and modifying these constructions as new experiences are revealed (Schwandt, 2000).

Biklen and Bogdan (1986) suggested two distinct modes of applying constructivist approaches to research: (a) the methods level – as a set of tools and techniques, and (b) the paradigm level – as a way of viewing the world. This research was conceptualized from the paradigm level which Biklen and Bogdan termed “thinking naturalistically” (p. 95). The constructivist paradigm “approaches reality as



a multi-layered, interactive, shared social experience that can be studied by first learning what participants consider important” (Biklen & Bogdan, p. 95). This paradigm addresses the richness and context of the research participants’ experiences regarding self-disclosure in this study and appreciates these as individualized experiences and voices.

The basic belief system of the constructivist paradigm is reflected in the answers to three questions: (a) What is there that can be known? (b) What is the relationship of the knower to the known (or knowable)? and (c) What are the ways of finding out knowledge? (Guba & Lincoln, 1989, p. 83). These questions reflect the ontological, epistemological, and methodological assumptions of research. This belief system defines the constructivist paradigm which, along with the philosophy of qualitative research identified by Creswell (1998), served as the guiding assumption from which this study was conceptualized and designed.

*Ontology.* Multiple social realities exist (Guba & Lincoln, 1989) that cannot be predicted or controlled (Lincoln & Guba, 1985). Instead, the multiple versions of reality can only be studied holistically to achieve understanding (Lincoln & Guba).

This research did not aim to predict, control, or explain self-disclosure for students with mood disorders in college. The purpose of this study was to explore and understand the participants’ experiences in their own words to gain understanding of the factors influencing self-disclosure.

*Epistemology.* Knowledge is mutually created by the researcher and the participants who are inseparable in the research process, interacting interdependently

to provide more understanding of the intersecting realities and experiences of researcher and participant (Guba & Lincoln, 1989; Lincoln & Guba, 1985).

My interactions with the participants occurred during interviews. Throughout the course of the study, these interactions allowed for rich and meaningful connections between the participants and me. Within the process of these conversations, it is likely that my interactions influenced the participants in this study just as they influenced and inspired this work.

*Methodology.* The methodology is designed to increase understanding and to make sense of the phenomenon being examined (Guba & Lincoln, 1989). Constructivists seek interpretive understandings of participants' meanings and utilize methods of data collection such as interviewing, observing nonverbal communication, and reviewing documents that reveal the multiple realities of the respondents (Lincoln & Guba, 1985). These methods capture the interaction between researcher and participant and provide more understanding of the interaction of "mutually shaping influences" (Lincoln & Guba, p. 40) that may occur.

The constructivist paradigm is consistent with the philosophical assumptions of qualitative research identified by Creswell (1998) and the methodology used to explore and understand the experiences and perspectives of the participants in this study. The following section further examines and defines the methodology that guides this study.

### Grounded Theory Methodology

Tuchman (1998) described methodology as "the study of epistemological assumptions implicit in specific methods" which "includes a way of looking at

phenomena that specifies how a method ‘captures’ the ‘object’ of study” (p. 226).

The grounded theory methodology was developed in 1967 by two sociologists, Barney Glaser and the late Anselm Strauss (Glaser, 1978; Glaser & Strauss, 1967; Strauss, 1987; Strauss & Corbin, 1990, 1998).

Eight assumptions contributed to the development of this methodology.

These are:

1. The need to get out into the field to discover what is really going on.
2. The relevance of theory, grounded in data, to the development of a discipline and as a basis for social action.
3. The complexity and variability of phenomena and of human action.
4. The belief that persons are actors who take an active role in responding to problematic situations.
5. The realization that persons act on the basis of meaning.
6. The understanding that meaning is defined and redefined through interaction.
7. A sensitivity to the evolving and unfolding nature of events (process).
8. An awareness of the interrelationships among conditions (structure), action (process), and consequences (Strauss & Corbin, 1998, p. 9-10).

In the 1990s, Glaser and Strauss diverged in their philosophy about the concept of grounded theory methodology and how to apply it to practice (Dey, 1999). Glaser’s (1978) stance resembled “traditional positivism, with its assumptions of an objective, external reality, a neutral observer who discovers data, reductionist inquiry of manageable research problems, and objectivist rendering of data” (Charmaz, 2000,

p. 510). Strauss later collaborated with Juliet Corbin and together they published introductory texts on grounded theory (Strauss & Corbin, 1990, 1998). Their position “assumes an objective external reality, aims toward unbiased data collection, proposes a set of technical procedures, and espouses verification” (Charmaz, 2000, p. 510). Although their approach does resemble attributes of positivism, it combines an interpretive tradition which gives voice to participants, explores and acknowledges the different views of reality between researcher and respondents, and incorporates creativity and science during the process of data analysis (Charmaz, 2000).

This study employed the grounded theory approach as defined by Strauss and Corbin (1990, 1998) and aimed to generate theory that focused on the interaction between individuals and the phenomenon under inquiry (Creswell, 1998; Dey, 1999). This methodology is particularly relevant for research that produces “new and theoretically expressed understandings” (Strauss & Corbin, 1998, p. 8) about concepts pertaining to a given phenomenon that have not yet been identified or are poorly understood (Strauss & Corbin, 1998). This study used grounded theory methodology to generate an emerging theory that illuminated the self-disclosure decision making process for college students with mood disorders, a phenomenon about which little is known or understood in higher education.

The purpose of grounded theory is to generate theory that is faithful to the area under study and that illuminates the phenomenon being examined (Strauss & Corbin, 1990). This approach entails interpreting the data and relating concepts through statements of relationships that form a theoretical framework about the phenomenon under study (Strauss & Corbin, 1990). A systematic set of procedures

guide the development of an inductively derived theory grounded in the actual words of the participants (Strauss & Corbin, 1990). Because grounded theories emerge from the data, they are “likely to offer insight, enhance understanding, and provide a meaningful guide to action” (Strauss & Corbin, 1998, p. 12).

### *Theoretical Sensitivity*

Theoretical sensitivity is a term frequently associated with grounded theory and refers to personal qualities of the researcher such as “having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn’t” (Strauss & Corbin, 1990, p. 42). Researchers who possess these qualities tend to generate theory that is grounded, conceptually sound, and well integrated (Strauss & Corbin, 1990). The degree of sensitivity with which a researcher enters a study depends upon his or her previous reading and personal and professional experience relevant to the phenomenon being examined. It can also be developed further throughout the course of the study (Strauss & Corbin, 1990).

Theoretical sensitivity is derived from a variety of sources including: (a) literature, (b) professional experience, (c) personal experience, and (d) the analytic process itself. Each is briefly described with corresponding illustrations that represent the theoretical sensitivity of the researcher of this study.

*Literature.* Both technical literature (e.g., reports on research studies, theoretical or philosophical papers) and nontechnical literature (e.g., biographies, diaries, and documents) stimulate theoretical sensitivity by providing concepts and relationships that can be compared to actual data or used to supplement interviews and field observations (Strauss & Corbin, 1990). The literature provides the

researcher with a rich background of information that “sensitizes” him or her to issues relevant to the phenomenon under study (Strauss & Corbin, 1990).

Strauss and Corbin (1990) cautioned the researcher against reviewing all of the literature prior to data collection and analysis because reviewing information that reveals previously identified categories and developed theory may constrain the researcher’s ability to discover relevant categories and the relationships among them.

Since discovery is our purpose, we do not have beforehand knowledge of all the categories relevant to our theory. It is only after a category has emerged as pertinent that we might want to go back to the technical literature to determine if this category is there. (Strauss & Corbin, 1990, p. 50)

There is little research or literature in higher education about students with mood disorders and their unique developmental issues. Previous studies of college students with disabilities largely have focused on physical and learning disabilities. The relatively few studies examining psychiatric disabilities in higher education have been limited to three themes: (a) guidelines, policy issues, and practices relative to academic accommodations and disciplinary procedures (Amada, 1985, 1986, 1997; Pavela, 1985; Unger, 1990, 1991); (b) the readiness of campus counseling centers to respond to the needs of individuals with serious mental illness (Chisolm, 1998; Guinee & Ness, 2000; Kiracofe, 1993; Stone & Archer, 1990; Stone, Vespia, & Kanz, 2000); and (c) supported education for students with psychiatric disabilities (Bateman, 1997; Becker, Martin, Wajeih, Ward, & Shern, 2002; Dougherty, Campana, Kontos, Flores, Lockhart, & Shaw, 1996; Unger, 1993). Literature in social and behavioral science disciplines examined societal stigma associated with

mental illness and address community-based interventions and rehabilitation for individuals with mental illness, but were not particular to higher education contexts (Davidson & Strauss, 1997; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989; Scheff, 1984; Socall & Holtgraves, 1992).

I reviewed literature including quantitative and qualitative research studies, biographies, and manuscripts on topics that were relevant to self-disclosure and mood disorders to develop concepts to inform this study without constraining my ability to generate a grounded theory. After the data were collected and analyzed and a theory had emerged, I returned to the literature that was reviewed in Chapter II to make connections between the new findings and previous research. In addition, I reviewed some new research to provide added comparison points and discover a deeper understanding of the grounded theory.

*Professional experience.* The experience gained through observation and practice in a field enhances theoretical sensitivity by providing the researcher with greater insight and deeper knowledge to inform research related to that field (Strauss & Corbin, 1990). Strauss and Corbin (1990) cautioned that this type of experience could also serve to block the researcher's ability to see things that have become routine or obvious.

My professional experiences related to mood disorders include: (a) designing curricular and cocurricular programs for college students, faculty, and staff; (b) serving on committees including the President's Commission on Disability Issues at a large, Mid-Atlantic university; and (c) working as an intern at the National Alliance for the Mentally Ill (NAMI) in Arlington, Virginia. These experiences provided me

with insight to make observations and understand the experiences of the participants in this study as they relate to self-disclosing a mood disorder, and allowed me to use this complex knowledge to inform the research study.

*Personal experience.* The researcher develops theoretical sensitivity by relying on personal experience related to the phenomenon being examined to make comparisons that stimulate the generation of relevant concepts and their relationships to the particular phenomenon, being careful not to assume that participants' experiences have been similar to one's own (Strauss & Corbin, 1990).

My personal experiences with mood disorders, inclusive of my continual struggle to accept my disability and to get others to accept me with respect to my disability, inform both my academic and professional vision and, in so doing, provide me a unique ability to understand and relate to the participants in this study and the issues they face. I acknowledged each participant's individuality and recognized that every student experienced his or her mood disorder uniquely.

*Analytic process.* Theoretical sensitivity is acquired during the research process as the researcher develops greater insight and deeper understanding about the phenomenon being studied (Strauss & Corbin, 1990). This knowledge is gained by interacting with the data and "increasing sensitivity to concepts, their meanings, and relationships" (Strauss & Corbin, 1990, p. 43).

Through the process of data collection and the analysis of data, I asked questions about data, made comparisons, and developed theoretical frameworks about concepts and their relationships. The research process enhanced my sensitivity to concepts and their meanings pertaining to this study. Further discussion in this



chapter explores and describes the analytic process including the use of peer debriefers and an inquiry auditor (Lincoln & Guba, 1985).

### Description of Participants

There were nine participants in this study. Each participant was currently enrolled in an undergraduate program at a large, Mid-Atlantic university, and was diagnosed as having bipolar disorder or major depressive disorder by a mental health professional. Three participants were diagnosed with bipolar disorder and three with major depressive disorder. In addition to these six participants, three participants who were initially diagnosed with major depression were rediagnosed as having bipolar disorder by their psychiatrists.

A brief description of each participant is provided as a guide to the reader and to facilitate understanding for the context of the participant's experiences and personal narratives. Some demographic information is also presented to illustrate the diversity, broadly conceptualized, that participants brought to the research. To protect their anonymity, the names used to identify the participants are pseudonyms, selected by the participants themselves. Each participant is introduced through personal characteristics and a quote highlighting his or her motivation to participate in this research.

#### *Alex*

Alex was a 21 year old heterosexual female. She identified as Caucasian with Western European background, Christian affiliation and from an upper middle class background. At the time this study was conducted, Alex was a junior with declared majors in the College of Behavioral and Social Sciences. In high school, she was

diagnosed with major depression by a psychiatrist but was re-diagnosed by another psychiatrist in September 2002 with bipolar disorder. Alex chose to participate in this study to “be able to talk about it and to be able to explore it and understand it more” and “because it showed me that there are other people on campus who do have bipolar and depression.”

*Amanda*

Amanda was a 19 year old heterosexual female who identified as a White American raised as a Catholic with an upper middle class background. At the time this study was conducted, she was a sophomore with a declared major in the College of Behavioral and Social Sciences. A psychiatrist diagnosed her with major depression when she was a senior in high school. Amanda participated in this study to contribute to efforts that advance knowledge about mental illness:

It was just nice to see that somebody was recognizing depression as an issue to be dealt with . . . This is the place for me to educate people without me being the one to directly say it. I know whatever is put together, this is going to do something somewhere and even though my name is not on it, I know I contributed. So if anything changes because of this, I know that I had an affect on that and I like that. It’s a good feeling to have.

*Billy*

Billy was a 23 year old heterosexual male. He identified as Caucasian and an Atheist and from a middle class background. At the time this study was conducted, Billy was a fifth year student majoring in the College of Arts and Humanities. A psychiatrist diagnosed him with bipolar disorder during his first year of high school.

Billy's motivation for participating in this study was to disseminate information about mental illnesses and people living with them and make it "real." He shared:

Real people stories just helps to illustrate it better than just theory that you might get in a Psychology class. I think it's just nice to get some information out there from real people.

*David*

David was a 27 year old heterosexual male who identified as Caucasian and Agnostic and from an upper middle class background. At the time this study was conducted, he had attended college for nine years, working toward completion of a degree in business. A psychiatrist diagnosed David with bipolar disorder during his second year in college. David took part in this study to increase understanding for people with mental illness:

Any sort of research that goes on that deals with mental illness, whether it deals with mental illness in college or in the workplace or anywhere, I think there is so much that is not known and there are still a lot of people out there who don't really know anything about mental illness and I think participating in this research contributes to people's understanding of mental illness and how people deal with it, especially when they're in college.

*Felicity*

Felicity was a 20 year old heterosexual female. She identified as biracial with Hispanic and Jewish backgrounds and Jewish religious affiliation from an upper middle class background. At the time this study was conducted, Felicity was a junior with a declared major in the College of Behavioral and Social Sciences. A

psychiatrist diagnosed her with major depression during her sophomore year in high school and he later re-diagnosed her in June 2002 with bipolar disorder. Felicity participated in this study to “help other people.” She shared:

Whatever I can do to help people who are like me, and then I want to do that. And also, I just wanted to talk to you and it does make me feel better to talk about things and it helps me understand myself too.

#### *Jennifer*

Jennifer was a 27 year old heterosexual female who identified as White with Irish, German, and American backgrounds and Methodist affiliation. She previously attended a community college and other post-secondary institutions where she completed approximately 12 semesters. At the time this study was conducted, she was a junior with a declared major in the College of Behavioral and Social Sciences. Jennifer identified as working class, married, and was the mother of a nine year old son. She was diagnosed with major depression at the age of 15. Jennifer took part in this study to further explore and understand her own experiences related to self-disclosure and living with depression:

I thought that it sounded interesting, although I thought that I would be wasting your time because I haven't really disclosed. I guess part of it was that I was getting tired of when someone would say something and I would get this jump in my stomach and I wanted to say something and I didn't. I'm getting tired of wondering why I'm not saying anything in those cases.

#### *June*

June was a 23 year old bisexual female who identified as a White American with no religious affiliation and from a middle class background. At the time this

study was conducted, she was a fifth year student with a declared major in the College of Behavioral and Social Sciences. A staff psychiatrist at the campus mental health center initially diagnosed her with major depression during her junior year in college. She was re-diagnosed with bipolar disorder in November 2002 by another staff psychiatrist at the campus mental health center. June chose to participate in this study because: “I thought that it would be a good way to help myself think through this stuff.”

*Olivia*

Olivia was a 20 year old heterosexual female. She identified as Caucasian with Italian, Scot Irish, and Norwegian backgrounds, from a middle class background, and with no religious affiliation. After completing two years of study at a college in North Carolina, Olivia transferred to a large, Mid-Atlantic university where she had completed one semester studying in the College of Arts and Humanities. She was diagnosed with bipolar disorder in October 2002 by a staff psychiatrist at the campus mental health center. Olivia participated in this study because it offered her an opportunity for her own self-exploration: “I thought it would be very interesting to hear what kind of questions you would ask me and I would be talking most of the time about my personal experiences.”

*X*

X was a 23 year old gay male who identified as African American with no religious affiliation and from an upper middle class background. At the time this study was conducted, he was in his fifth year of college with a declared major in the College of Social and Behavioral Sciences. X was diagnosed with major depression by a psychiatrist during his first year in college. He took part in this study to provide

support to others living with mental illness: “This research I feel can be used to better help people who have gone through what I have gone through and maybe make things a little bit easier to get through life.”

## Data Sources

### *Interview Method*

As an exploratory and descriptive study, this research was guided by “depth interviewing” which entails asking open-ended questions to illuminate the participant’s perspective in relation to the phenomenon being explored (Patton, 1987, p. 108). This form of interviewing adheres to the assumption that “the perspective of others is meaningful, knowable, and able to be made explicit” (Patton, 1990, p. 278). The qualitative researcher engages in depth interviewing to explore “beneath the surface, soliciting detail and providing a holistic understanding of the interviewee’s point of view” (Patton, 1987, p. 108). The purpose of the interviews was to engage in conversation with participants to explore their decision making process about self-disclosing a mood disorder in college.

Patton (1987) identified three qualitative approaches to depth interviewing: (a) the informal conversational interview, (b) the general interview guide approach, and (c) the standardized open-ended interview.

The informal conversational interview technique involves an open-ended approach in which no predetermined questions are established (Patton, 1987). This interview method which flows with the participant’s responses to the previous question is highly conducive to individual differences and varying situations, but can be extremely time intensive (Patton, 1987).

The general interview guide approach provides a framework for the interview itself and entails developing an outline of topics and issues to be covered during the interviews to make data collection more systematic and comprehensive (Patton, 1987). This technique allows the researcher “to build a conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style – but with the focus on a particular predetermined subject” (Patton, 1987, p. 111).

The standardized open-ended interview consists of prearranged questions that are asked in the same sequence with essentially the same words with each respondent in order to minimize the bias that can occur from asking different questions of each respondent (Patton, 1987). By asking the exact questions of all participants, this interviewing approach limits the researcher from further pursuing and exploring areas that may illuminate the research.

This study used a combination of the informal conversational interview and the general interview guide approaches to depth interviewing. Initial questions resembling the interview guide approach were used to guide the study. Subsequent questions were asked following the informal conversational interview approach in which questions were formulated from emerging topics shared by the participants themselves. Throughout the process of data collection, the initial research questions guiding the study were used to refocus interviews and explore questions more deeply (Appendix F).

Patton (1987) suggested that the interviews be designed to provide a context for participants to communicate in their own words their understandings, meanings,

and personal perspectives related to the phenomenon being examined. The emphasis on exploring the experience of participants remained true to the recollections, perspectives, and feelings of the participants themselves as told in their own words. The depth interviews provided both structure and flexibility, and allowed the researcher and participant to engage in dialogue that was conversational in nature which permitted the researcher to present new questions as they emerged from conversation while maintaining the flow of the interview (Patton, 1987).

### *Document Analysis*

Document analysis was a secondary source of information which added depth to this study. Documents are rich sources of information that are “contextually relevant and grounded in the contexts they represent” and “appear in the natural language of that setting” (Lincoln & Guba, 1985, p. 277). For the third interview, participants were asked to share short stories, journal entries, scrapbooks, photographs, newspaper and magazine articles, poetry, art, and song lyrics, or other materials that they felt captured their experiences living with a mood disorder. Document reviews didn’t directly inform self-disclosure, the focus of this study, but were referenced through selected quotations that illustrated certain key categories and subcategories (i.e., *Receiving Diagnosis*, *Constructing an Illness Identity*). Document analysis was used to add depth to the study. Through this experience, the participants were able to uniquely express themselves and add a new dimension to their narratives through the sharing of materials that held personal meaning for them. Document analysis also provided an opportunity for the researcher to more deeply and intimately



engage with participants. Materials shared for document analysis are presented in Appendix I.

## Procedures

### *Sampling*

Consistent with the exploratory and descriptive aims of qualitative research, the strategy of participant selection “rests on the multiple purposes of illuminating, interpreting, and understanding – and on the researcher’s own imagination and judgment” (Glesne & Peshkin, 1992, p. 27). The following sections describe two sampling strategies utilized in this study: (a) theoretical sampling, and (b) purposive sampling.

*Theoretical sampling.* This study employed a sampling strategy termed “theoretical sampling” to select research participants. Strauss and Corbin (1998) defined theoretical sampling as,

data gathering driven by concepts derived from the evolving theory and based on the concept of “making comparisons,” whose purpose is to go to places, people, or events that will maximize opportunities to discover variations among concepts and to identify categories in terms of their properties and dimensions. (p. 201)

Sampling evolved during the research process and sampling procedures were based on “concepts that emerged from analysis and that appear to have relevance to the evolving theory” (Strauss & Corbin, 1998, p. 202).

In grounded theory studies, the researcher uses theoretical sampling to select participants based on their ability to contribute to the evolving theory (Creswell,

1998). “The aim of theoretical sampling is to maximize opportunities to compare events, incidents, or happenings to determine how a category varies in terms of its properties and dimensions” (Strauss & Corbin, 1998, p. 202). By maximizing opportunities to compare concepts for similarities and differences at various points throughout the study, the researcher is able to identify and generate richly developed categories.

As the study progressed, data analysis informed continued participant selection (Glesne & Peshkin, 1992) and continued until the point of theoretical saturation of each category generated was achieved (Glaser & Strauss, 1967). Strauss and Corbin (1998) referred to theoretical saturation as reaching the point in the research where no new or relevant information emerges and collecting additional data seems counterproductive because it does not add that much more understanding to the phenomenon under study. Lincoln and Guba (1985) referred to this criterion used to determine when to stop sampling as “selection to the point of redundancy” (p. 202). The goal of this sampling strategy was to “refine ideas, not to increase the size of the original sample” (Charmaz, 2000, p. 519, *italics original*). Theoretical sampling was conducted to fill gaps in the data collected, identify conceptual boundaries, and make emerging categories more definitive and useful (Charmaz, 2000). In this study, sampling continued until little new or relevant information emerged regarding a category and the relationships among categories were well established and theoretically sound.

*Purposive sampling.* Qualitative researchers utilize purposive sampling (Patton, 1980) to select participants who are “information-rich cases” from whom a great deal can be learned about a specific phenomenon (Patton, 1990).

This study employed two types of purposive sampling to select participants. Snowball or chain sampling was utilized first to locate “key informants, individuals who provide useful insights into the group and can steer the researcher to information and contacts” (Creswell, 1998, p. 60). Maximum variation sampling provided information-rich participants who informed identified characteristics important to the research (Patton, 1990). The strategy of maximum variation sampling was used to select participants who represented diverse backgrounds (i.e., race, ethnicity, gender, socioeconomic status, sexual orientation, religion/faith, age, time of diagnosis, etc.).

The snowball sampling technique was used when I contacted the counseling center staff, mental health services staff, and other administrative staff or faculty members who were thought to be knowledgeable informants about how and where to contact potential participants. These informants are referred to as “gatekeepers” (Lincoln & Guba, 1985). These gatekeepers were each given a letter introducing the study and asking for their interest to locate participants (Appendix B). In addition, they were given a research interest form (Appendix D) and were asked to share it with students who they believed are rich in information regarding the phenomenon being examined and who may have an interest in participating in this study.

A variety of strategies were utilized to identify a diverse group of participants. The following measures were taken to include students from diverse backgrounds: (a) posting fliers in the University’s Counseling Center and Mental Health Center and in

various academic buildings (Appendix C), (b) sending an invitational cover letter (Appendix A) and the research interest form (Appendix D) to listservs of various student groups including the Black Student Union, the Asian American Student Union, and the Latino Student Union, (c) visiting two undergraduate Psychology classes to share information about the study and distribute invitational cover letters and research interest forms, and (d) placing phone calls to staff members who work in diversity-related units on campus.

#### *Participant Identification and Selection*

Recruitment of participants began in October 2002, after obtaining the approval of the university human subjects committee. Interested respondents returned the research interest form (Appendix D) or contacted the researcher by email or telephone (individuals who initiated contact with the researcher by phone or email subsequently filled out the research interest form). These potential participants then received a follow-up telephone call from the researcher who asked them to share other ways in which they identify themselves (i.e., race, ethnicity, sexual orientation, socioeconomic status, and religious/spiritual affiliation) for purposes of maximum variation sampling. Students were given the option not to respond to questions that may be uncomfortable for them or that they were not willing to disclose.

Sampling in qualitative research is guided by a conceptual question and emphasizes “information-rich cases” (Patton, 1990) to maximize information, rather than a concern for a representative sample that facilitates generalization. And, according to Lincoln and Guba’s (1985) guidelines, approximately 10-12 students would be an appropriate number of participants to include in the sample, since

exceeding 10-12 would likely result in selection to the point of redundancy. Students who fit the selection criteria (described below) and responded to sampling efforts were invited to participate in three interviews, each expected to be of 1 to 1 1/2 hours duration. The participants were contacted via electronic mail and telephone and invited to participate in the study and to schedule the first interview. Ten participants were confirmed to participate by November. Participant recruitment continued through January 2003, when one additional participant was chosen to take part in the study.

The research criteria required that each participant be a current undergraduate college and diagnosed as having bipolar disorder or major depressive disorder by a mental health professional. All other characteristics of the participants were used to maximize variation of the sample. These selection criteria were established because students who possess these characteristics will likely have rich stories to share about how they make decisions about self-disclosing a mood disorder while in college.

Of the eleven students who initially were selected to participate in the study, two participants were eliminated from the participant pool during the first round of interviews. Both students participated in the initial interview but did not complete subsequent interviews. One student asked me to stop the tape recorder during the first interview. She shared that the experience of recalling events that related to her mood disorder raised too many painful memories and that she could not continue her participation in the following interviews. I thanked the student for her time and reiterated that her participation was voluntary and that she was free to withdraw from the study at anytime. With the student's permission, I called the campus counseling

center and assisted her in scheduling an appointment with a staff psychologist who would provide further assistance and support. The other student completed the first interview but later decided that her participation in the study took time away from her course work and she could not commit the needed time to participate in the second and third interviews. I offered to arrange subsequent interviews at alternative times and locations (e.g., her residence hall) to make her participation in the study more convenient and to avoid conflicts with her academic schedule, but she decided that withdrawing from the study was best for her. Again, I thanked her for her time and energy and reminded her that her participation in the study was voluntary and that I respected her decision to withdraw from the study.

Initial interviews began in November and final interviews concluded during the first week of March 2003. Upon completion of the study, participants were each given a \$25 gift certificate to Target stores in appreciation for their involvement in the research.

### *Pilot Study*

A previous study conducted in spring 2001 (Farzad Nawabi, 2001) served as a pilot for this study. Through personal contacts, two students with bipolar disorder and one diagnosed with major depressive disorder agreed to participate in one interview lasting 60-90 minutes to explore critical incidents contributing to self-disclosure for students with psychiatric disabilities. These participants, like those in the participant pool, were currently enrolled in an undergraduate program at a large, Mid-Atlantic university and diagnosed as having bipolar disorder or major depression

by a mental health professional. Findings from the pilot study are presented in Chapter II.

The pilot study was instrumental in shaping this research process since the participants shared their reflections and provided helpful suggestions about the content and sequence of the interview questions. The feedback from the pilot study participants assisted the researcher in revising and refining initial questions used in this current study.

This research expanded on the pilot study and extended the scope of that study to include the perspectives and experiences of nine participants diagnosed with bipolar disorder or major depressive disorder. The findings from the pilot study informed this research by providing a context from which to understand how students interpret and make meaning of the messages they receive about mood disorders on campus and how this influenced their decisions about self-disclosure.

### *Individual Interviews*

The current study involved three interviews conducted with each of the participants throughout the fall 2002 and spring 2003 semesters and concluded during the month of March 2003. Each interview lasted approximately 60-90 minutes and was audiotaped.

I transcribed interviews within a week of the interview to avoid a substantial time lapse between subsequent interviews since the ability to process data is considerably reduced when “the interview is no longer fresh in the interviewer’s mind” (Lincoln & Guba, 1985, p. 272).

One to two weeks after each interview, participants were sent a transcript cover letter (Appendix G) and a typed transcription of their interview as an attachment via email, by U.S. mail, or by another method they prefer (e.g., some students opted to pick up the materials directly from the researcher) for review and comments. This process allowed the participants an opportunity to clarify, substantiate, or expand on certain points shared during each individual interview.

Each participant was asked to do the following within five days of receiving the transcription for his or her interview: (a) review the transcription; (b) make written notes; (c) contact the researcher by phone to schedule a subsequent interview after completing the transcript review; and (d) return the completed transcript review at the subsequent interview (Appendix G). If I did not hear from participants within seven to ten days after sending them the interview transcriptions, I initiated contact myself by phone to follow up and schedule subsequent interviews.

Each initial interview began with the researcher's remarks about the purpose of the study, her interest in hearing individual perspectives and experiences, and with the completion of the informed consent form (Appendix E). To provide them with additional sources of support, participants were each given a handout outlining campus and community services and published references (Appendix H).

During the initial interview, broad open-ended questions were asked to gain understanding of the participants' initial thoughts and reflections concerning the phenomenon. Introductory questions (Appendix F) were used as starting points to initiate dialogue. Questions for subsequent interviews were designed to explore deeper issues of self-disclosure and were generated through data analysis of previous



interviews. This initial interview allowed the researcher to develop rapport and nurture trust with the participants, and to set the context for the inquiry.

A second interview was scheduled with each participant which consisted of more in-depth questions (Appendix F) which were informed from analyzing data collected during the initial interview. The questions addressed issues common to all participants as well as issues specific to an individual to generate new topics and to obtain detail and description around the emerging concepts.

A third interview was conducted with each of the participants. During this interview, questions were designed to gain deeper understanding of the categories and the emerging theory and to ensure that the data were saturated. Three interviews were sufficient for data collection since saturation of data was reached. At the conclusion of the third interview, each participant was asked to share materials for document analysis that they felt captured their experiences living with a mood disorder which added depth to the study (Appendix I). All participants agreed to be contacted by the researcher via email should clarification be necessary during the process of writing the results.

### *Ethical Considerations*

Ethical issues presented by this inquiry were considered both before and during the research process. The study was conducted carefully and thoughtfully to minimize any potential risk to participants as a result of their involvement in the research. Interviews were conducted in a private campus office and audiotaped, with permission of each participant. Prior to each initial interview, the purpose of the study was clearly conveyed to participants both verbally and in writing through the

research interest form (Appendix D) and the written consent form (Appendix E).

Participants were informed that their participation was strictly voluntary and that they may choose to withdraw at any time during the study. Participants were encouraged to ask questions and were given the option to stop the tape or end the interview at any time.

The issue of confidentiality was addressed through the use of the informed consent form and participants were assured that their anonymity was protected at all times. The participants were told that excerpts of their interviews would be used in the written reporting of this study, but that their names would not be used. Their right to privacy was respected by not identifying participants by their name to anyone verbally or in any written material. To ensure their confidentiality, participants were asked to select a pseudonym of their choice. With permission of each participant, members of the research team (i.e., inquiry auditor and peer debriefers) reviewed transcriptions of interviews. Tapes from interviews were heard only by the researcher and were securely stored in a locked drawer in the researcher's office.

During the initial interviews, each participant was provided with a campus and community resource handout (Appendix H) which outlined services and published references that may serve as additional sources of support and help distinguish my role as a researcher and not as a counselor. Prior to the study, I asked a professional from both the counseling center and the mental health center on campus to serve as referrals to students who may seek additional support and listed their names and contact information on the campus and community resource handout.

## Data Analysis

Data analysis using grounded theory methodology is termed “coding” to represent the process by which data are broken into smaller parts, categorized, examined, and then conceptualized in new ways (Strauss & Corbin, 1990). To facilitate knowledge of coding procedures, it is helpful to understand the purposes of data analysis using grounded theory procedures. These are:

1. Build rather than only test theory.
2. Give the research process the rigor necessary to make the theory “good” science.
3. Help the analyst to break through the biases and assumptions brought to, and that can develop during, the research process.
4. Provide the grounding, build the density, and develop the sensitivity and integration needed to generate a rich, tightly woven, explanatory theory that closely approximates the reality it represents (Strauss & Corbin, 1990, p. 57).

This study employed inductive data analysis to provide more understanding of the interaction of “mutually shaping influences” and the interacting realities and experiences of researcher and participant (Lincoln & Guba, 1985, p. 40). Inductive data analysis involved unitizing and categorizing (Lincoln & Guba). Searching for an element (phrase, sentence) that is aimed at some understanding or action unitizes data (Lincoln & Guba). Once the data were unitized, related units were grouped together in categories. The categories were examined for patterns and to identify themes used

to uncover the critical incidents contributing to self-disclosure and to make general interpretations (Lincoln & Guba).

An analytic procedure that is fundamental to the coding process in grounded theory is “the constant comparative method of analysis” (Glaser & Strauss, 1967). This categorizing process of qualitative data involves organizing the unitized data into categories on the basis of similar characteristics or qualities (Lincoln & Guba, 1985) which are then continuously compared to other categories to develop larger constructs (Strauss & Corbin, 1990). In this study, the constant comparative method was used to analyze the data by identifying each critical incident as an individual unit.

#### *Coding Procedures*

Coding strategies in grounded theory involve three forms of coding: (a) open coding, (b) axial coding, and (c) selective coding (Strauss & Corbin, 1990, 1998). These coding procedures are not sequential acts, but continue to emerge during analysis (Strauss & Corbin, 1998). The following section describes the three levels of coding that were used to analyze the data in this study.

*Open coding.* Grounded theory data analysis begins with open coding during which “data are broken down into discrete parts, closely examined, and compared for similarities and differences” (Strauss & Corbin, 1998, p. 102). The open coding process began by carefully examining the words used by participants to describe and express their experiences, understandings, and insights. Each word, sentence, and phrase was examined and labeled as a concept or “labeled phenomenon” (Strauss & Corbin, 1998, p. 103). Through the process of open coding, 1804 concepts were identified from the data. As concepts emerged and appeared to be “similar in nature

or related in meaning” (Strauss & Corbin, 1998, p. 102) they were clustered together to develop abstract categories that revealed phenomena around the emerging theory.

According to Strauss and Corbin (1998), discovering categories reflects greater abstraction, complexity, and “analytic power because they have the potential to explain and predict” (p. 113). Categories were named to reflect and describe what the data revealed by using the participants’ own words. Strauss and Corbin (1990, p. 69) referred to naming or labeling a category with the words used by the participants themselves as “‘in vivo’ codes” which add density to the research by providing grounding in the actual words of the participants. The transcripts were returned to participants after each interview to insure that category names appropriately reflected the actual words of the individuals and the meaning they intended to convey in their stories.

Open coding also involves the development of properties and dimensions which provide richness, description, and specificity to emerging categories. Strauss and Corbin (1998) described properties as “the general or specific characteristics or attributes of a category” and dimensions as “the location of a property along a continuum or range” (p. 117). Examining categories in terms of their properties and dimensions increases knowledge about a concept, describes how properties vary along their dimensional ranges, and differentiates a category from other categories (Strauss & Corbin, 1998).

*Axial coding.* The goal of axial coding, the second level of grounded theory coding, is to “systematically develop and relate categories” (Strauss & Corbin, 1998, p. 142). This process involved reconfiguring the data after open coding to make

connections among categories and develop more precise and complete understandings about phenomena (Strauss & Corbin, 1990, 1998). Categories were compared and evaluated along their properties and dimensions to identify relationships among categories, formulate patterns, and establish integration of categories. During this process of data analysis, the developing categories and supporting concepts were written on index cards and later inputted onto a spreadsheet to assist with comparing categories and determining relationships among categories. This coding process resulted in the identification of 42 broad and conceptual categories constructed from the over 1800 initial concepts.

*Selective coding.* The final level of coding in grounded theory is selective coding which involves “the process of selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development” (Strauss & Corbin, 1990, p. 116). Strauss and Corbin (1990) defined a core category as “the central phenomenon around which all the other categories are integrated” (p. 116). During selective coding, categories were examined to determine whether or not theoretical saturation had been reached, which meant that no new properties, dimensions, or relationships emerged from data analysis. Through this coding procedure, the developed categories were integrated, refined, and grounded in the data to generate a grounded theory. The core category, *Lifting the Veil*, and five key categories were identified to develop the emergent theory.

### *Summary of Data Analysis*

Grounded theory was generated through a process of data analysis which involved three levels of coding – open, axial, and selective. The words and experiences of the participants provided the raw data which were initially identified as concepts and then linked as abstract categories, analyzed for the relationships among categories, and formulated into integrated categories. This analytic process concluded in the generation of a grounded theory which emerged from the data and illuminated the words and experiences of the participants themselves.

### *Considerations for Establishing the Integrity/Trustworthiness of Qualitative Research*

#### *Establishing Rapport*

Glesne and Peshkin (1992) suggested that rapport makes significant contributions to qualitative research and is an integral part of data collection. They described rapport as a “distance-reducing, anxiety-quieting, trust-building mechanism” in qualitative research (p. 94). Establishing rapport with participants was essential to this research process so that the participants felt comfortable discussing and disclosing information related to their mood disorder. I conveyed to participants that their knowledge, insights, and experiences provided unique and important contributions to the research and that their time and attention were worthy and much appreciated.

According to Glesne and Peshkin (1992), “a relationship characterized by rapport is marked by confidence and trust” (p. 94). I established trust and maintained positive relations with the participants and gained their confidence by demonstrating empathic understanding of and respect for their perspectives and experiences.

Conveying empathy and understanding for the participants and their stories without judgment developed rapport. I was nonjudgmental and communicated to participants that there were no right or wrong responses and that I was interested in hearing each participant describe his or her experiences with respect to self-disclosing a mood disorder. I was an active and thoughtful listener and respected silences that occurred as participants shared difficult stories. I was friendly and sincere and presented myself to participants as someone who was invested in hearing and understanding their perspectives and experiences.

To facilitate participant responses and build trust, I spoke with each participant prior to the initial interview to discuss the researcher's role, the purpose of the study, possible uses of the data, and to describe how the participants could engage in the research. Rapport was established by ensuring that the participants' privacy and confidentiality were protected at all times. By developing and maintaining rapport with the participants, I affirmed each participant as a valued contributor to this research and created an environment conducive to the active sharing of personal stories related to self-disclosing a mood disorder.

#### *Establishing Trustworthiness*

The basic question regarding trustworthiness in qualitative research is: "How can the inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of?" (Lincoln & Guba, 1985, p. 290). Lincoln and Guba (1985) identified four criteria to establish trustworthiness: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability.



## *Credibility*

Lincoln and Guba (1985) suggested a variety of techniques for improving the likelihood that findings and interpretations produced through constructivist inquiry methods are credible. This study employed several strategies to achieve the criterion of credibility including: (a) prolonged engagement, (b) triangulation, (c) peer debriefing, and (d) member checks.

*Prolonged engagement.* Lincoln and Guba (1985) described prolonged engagement as spending sufficient time with participants to learn the culture, test for potential misunderstandings of the researcher or of the respondents, and build trust. I spent time with the participants over a period of five months within the contexts of reviewing logistics related to the study and conducting the interviews. This prolonged engagement allowed me to learn about the campus culture from the participants' perspectives, regularly check for any misunderstandings between the participants and myself, and develop a sense of trust with the participants I interviewed.

*Triangulation.* The technique of triangulation was used to establish credibility by relying upon multiple sources of data (the nine participants) and multiple methods of data collection (three individual interviews). Credibility was met by comparing the data obtained from the various sources and methods of collection and identifying areas of intersection.

*Peer debriefing.* Lincoln and Guba (1985) described peer debriefing as “a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the inquiry that might otherwise

remain only implicit within the inquirer's mind" (p. 308). The peer debriefers for this study were two doctoral students in a student affairs program at a large, Mid-Atlantic university. They were chosen to participate in this study because of their knowledge about qualitative analysis and I anticipated that they would bring perspectives different from my own to the study. The debriefers contributed to this research process by keeping me "honest" (Lincoln & Guba, p. 308) and challenging my biases and interpretations. We met as a group three times throughout the course of the study, discussing the design of interview questions, reviewing methodology and procedures to ensure the integrity of the process, testing my working hypotheses, and framing the study. In addition, I corresponded with each of them individually when I needed additional clarification.

*Member checks.* Member checking is a process through which participants verify data, interpretations, and conclusions (Lincoln & Guba, 1985). Each participant received a copy of his or her individual interview transcripts for review, clarification, verification, and suggestions. In addition, each participant was provided an opportunity during final analysis to review a more fully developed emerging theory, discuss interpretations, add information, and correct errors. The researcher sent an email to each participant requesting individual meetings to share emergent categories from the data analysis process and to gain member feedback. David and Jennifer responded to the request and agreed to meet with me. Each provided valuable reflections on the emergent themes and offered feedback that provided depth and support to the analysis process. All data were verified through this process which

established credibility to the inquiry by examining the researcher's construction of the participants' realities.

### *Transferability*

The nature of qualitative inquiry is dependent on a specific time and context and does not aim to produce generalizations (Lincoln & Guba, 1985). Instead, researchers present data through "thick description" (Lincoln & Guba, p. 316) to achieve the criterion of transferability. In-depth, communicative descriptions of the experiences of the participants relative to self-disclosure are provided to enable other researchers to make informed decisions regarding the appropriateness of transferability to other settings.

### *Dependability*

To establish dependability, an "inquiry auditor" (Lincoln & Guba, 1985) was selected to examine the process by which the research was conducted (e.g., sampling, interviews, data collection, etc.) and to verify the product of the inquiry (e.g., analysis of data, interpretation, and findings). A doctoral candidate in a student affairs program at a large, Mid-Atlantic university served as the auditor for this study. He was chosen for his working knowledge of and experience with qualitative research. In this role, he reviewed the data collection, methodology, and analysis processes for consistency and applicability to substantiate the authenticity of the study and dependability of the final analysis. Upon completing the tasks associated with this role, the inquiry auditor confirmed dependability of this study in a letter (Appendix K).

### *Confirmability*

The criterion of confirmability was established through the audit trail and the techniques of triangulation and reflexive journaling (Guba, 1981; Lincoln & Guba, 1985). The audit trail provided a system for organizing and compiling the documents and materials that were used during the inquiry and intended to establish that the findings described in a study were grounded in the data (Lincoln & Guba).

Correspondingly, I maintained a record of the inquiry process, as well as copies of all taped interviews, notes from the interviews, hard copies of all transcripts, and notes regarding working hypotheses, categories, findings, and interpretations. In addition, the process for establishing dependability described above also established confirmability in its function of establishing an audit trail.

Guba (1981) recommended maintaining a reflexive journal to record reflections about personal experiences as the researcher, and to also document methodological decisions made and corresponding rationale. The journal includes a schedule of activities and logistics and a log to record decisions and rationale. The reflexive journal served as an instrument for me to explore and clarify personal biases, assumptions and reactions stimulated by the research process. A copy of this journal was given to the inquiry auditor to inform the inquiry audit.

### Chapter Summary

This chapter described the mode of inquiry, inquiry paradigm, methodology, procedures, and data analysis used to conceptualize and design this research. In addition, considerations for establishing integrity and trustworthiness in qualitative research were presented. This study was a qualitative inquiry using grounded theory

methodology to build an emergent theory that revealed a deeper understanding of the participants' experiences related to self-disclosure.

## CHAPTER IV

### FINDINGS

The findings explored in this chapter reveal the experiences of nine undergraduate students as they described how and when they make decisions about self-disclosing a mood disorder while in college and the factors that influence their decisions. This chapter presents in-depth examinations of the core category – *Lifting the Veil* and each of the five key categories – *Receiving Diagnosis*, *Constructing an Illness Identity*, *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality* and their respective subcategories that provide dimension and illumination to the phenomenon of study. In this chapter, the *core category* and the five *key categories* are identified in italics; their Subcategories are identified through capitalization of the first letter. The chapter begins with an articulation of the emergent theory described through the core category and the five key categories.

#### Lifting the Veil on Invisible Identities: A Grounded Theory of Self-Disclosure for College Students with Mood Disorders

*Lifting the Veil on Invisible Identities: A Grounded Theory of Self-Disclosure for College Students with Mood Disorders* is the emergent theory that developed through analysis of narratives shared during three individual interviews with each participant. Through the rich stories and experiences shared by nine undergraduate students, the factors influencing their decisions about self-disclosing a mood disorder are presented in a visual model (Figure 1). A listing of the emergent categories and their respective subcategories that are subsequently described in this chapter can be found in Appendix J.

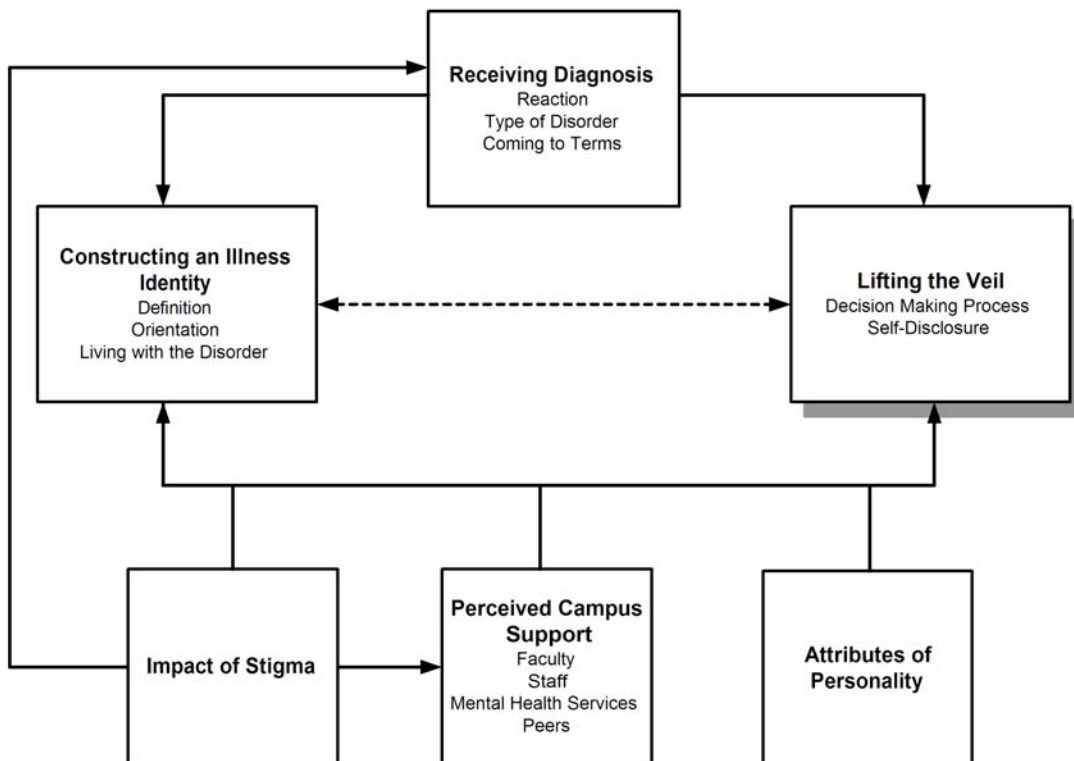


Figure 1: Lifting the Veil on Invisible Identities: A Grounded Theory of Self-Disclosure for College Students with Mood Disorders

Each of the five key categories complemented the core category *Lifting the Veil*, and contributed to the development of the emergent theory which explored and described self-disclosure for college students living with bipolar disorder or major depression. The core category described the decision making process that guided the participants' self-disclosures and the act of self-disclosure. *Receiving a Diagnosis* of bipolar disorder or major depression initiated the self-disclosure process for each participant. *Receiving a Diagnosis* led participants to the process of *Constructing an Illness Identity* in which they described their outlook on mental illness, constructed and negotiated the meaning of their identities as people with mental illness, and expressed how their mood disorders impacted their lives. The remaining factors or key categories contributing to an understanding of self-disclosure are *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*.

#### Relationship of Key Categories to Core Category

Each of the five key categories is integrally connected to the core category, *Lifting the Veil*. The experience of self-disclosure for college students with mood disorders was rooted in *Lifting the Veil*, *Receiving Diagnosis*, *Constructing an Illness Identity*, *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*. The relation of the key categories to the core category is described in this section. This paradigm is specific to grounded theory research and consists of a unique set of relationships with respect to the phenomenon under study (Strauss & Corbin, 1990, 1998). Causal conditions are “the events or incidents that lead to the occurrence or development of a phenomenon” (Strauss & Corbin, 1990, p. 100). Intervening conditions are aspects that “act to either facilitate or constrain the action/interactional



strategies taken within a specific context” (Strauss & Corbin, 1990, p. 103). Strauss and Corbin (1990) described consequences as “action and interaction taken in response to, or to manage, a phenomenon” (p. 106). Strauss and Corbin (1998) noted that “the relationship between conditions and consequences and subsequent actions/interactions rarely follows a linear path” (p. 183). That is, a condition rarely leads to an action/interaction and then to a consequence in a direct manner; rather, action/interaction may be taken in response to multiple conditions. The narratives presented in this current study revealed that self-disclosure is complex and is not manifested with regularity for all participants or in all situations. The students identified specific contexts (i.e., situations and settings) in which self-disclosure occurred and described their decisions to reveal a mood disorder while in college as a function among many variables and conditions.

The stories of the nine participants in this study showed that individuals began the self-disclosure process by *Receiving Diagnosis* of bipolar disorder or major depression (causal condition). Participants engaged in a process of *Constructing an Illness Identity* (intervening condition) in which they described their outlook on mental illness, constructed and negotiated the meaning of their identities as people with mental illness, and expressed how their mood disorders impacted their lives. The remaining factors or key categories contributing to an understanding for how and when students make decisions about self-disclosure relate to the core category as intervening conditions: *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*. The core category itself, *Lifting the Veil* described the self-disclosure

decision making process and the act of disclosure. As such, it described an action taken and represented the condition of consequence.

### Description of Model

The visual model (Figure 1) illustrates the core category and the five key categories and reveals their interrelationships. An arrow from *Receiving Diagnosis* leads to both *Lifting the Veil* and *Constructing an Illness Identity* because it exerts an influence on both processes. For example, some participants felt relieved after being diagnosed as having bipolar disorder or major depressive disorder and engaged in self-disclosure (*Lifting the Veil*) without processing their sense of identity with respect to their illness or considering how it impacted their lives (*Constructing an Illness Identity*). For the participants who were in denial and disbelief about receiving a diagnosis, self-disclosure was not an option. Instead of immediately engaging in self-disclosure, they instead began the process of negotiating the meaning of their illness identities, thereby experiencing *Constructing an Illness Identity*. To demonstrate the mutual influences between *Lifting the Veil* and *Constructing an Illness Identity*, Figure 1 shows a bi-directional arrow between the core category and this key category to show that as participants became more comfortable with their illness identities (engaging in the process of *Constructing an Illness Identity*), they engaged in self-disclosure (*Lifting the Veil*). And, as students began to self-disclose, their experiences informed their outlook on their mental illness and their sense of identity with respect to their mood disorder (*Constructing an Illness Identity*).

*Impact of Stigma* permeated the core category and all but one key category. Students' perceptions of mental illness stigma were pervasive and impacted their

experiences related to *Receiving Diagnosis*, *Constructing an Illness Identity*, *Lifting the Veil*, and *Perceived Campus Support* (as the arrows show in Figure 1). The data revealed that *Impact of Stigma* did not directly connect to *Attributes of Personality*.

The remaining categories, *Perceived Campus Support* and *Attributes of Personality*, influenced the participants' experiences related to *Constructing an Illness Identity* and *Lifting the Veil* (as the arrows demonstrate in Figure 1). The students who felt supported on campus (*Perceived Campus Support*) reported more positive feelings about their illness identities (*Constructing an Illness Identity*) and were encouraged to self-disclose (*Lifting the Veil*). The students who did not perceive a high level of support on campus (*Perceived Campus Support*) were left with negative feelings about their illness identities (*Constructing an Illness Identity*) and felt inhibited to reveal a mood disorder (*Lifting the Veil*).

Finally, personal characteristics (*Attributes of Personality*) impacted their outlook on mental illness, sense of identity with respect to illness, and how their mood disorder impacted their lives (*Constructing an Illness Identity*) as well their willingness to self-disclose (*Lifting the Veil*).

### The Story of the Self-Disclosure Process

The story of self-disclosure for undergraduate students diagnosed with mood disorders is highlighted through the participants' narratives and descriptions. Their quotations illuminate the core category and the five key categories of the emergent theory.

The story of the self-disclosure experiences for undergraduate students diagnosed with mood disorders is illustrated through the voice of Billy, a participant who described self-disclosure using a metaphor of lifting a veil. He shared:

I want people to look at mental illness as a real life problem, understand what it's about and move on. I don't want people to feel distant from it. Just mental illness in general, if you can tell someone what mental illness is like, then that is lifting the veil because you're kind of taking away that image that they have in their mind about what a mentally ill person is and showing them what a mentally ill person really looks like. People might have a veil of ignorance. That veil can also be a barrier in my relationship with someone that I want to get closer to and if I lift that veil, then we can get closer and not have that keep us apart . . . The veil is misunderstanding. When I think of a veil I think of something that doesn't completely cover you but that you can't see through either. Someone looking from the outside sees you in an obscured way and they don't have a real understanding of who is under there and I think the veil is maybe public misinterpretation of mental illness . . . It's a veil of ignorance and when it's there, what somebody is seeing when they look at me is blurry and they don't know enough about the illness to know how to unblurry it. If I am able to inform them about it, then I think they'll be able to feel closer to me and understand that I'm a human being.

Billy's words described his perceptions of how others viewed him given their lack of understanding and acceptance of mental illness. Billy's struggle to be understood as a person living with a mood disorder was a common experience shared

by the participants of this study. This exploration of students' voices related to having and self-disclosing a mood disorder in college revealed findings that described their perceptions, concerns, and experiences with respect to the phenomenon being explored.

#### Core Category: Lifting the Veil

The story line is transformed into the central or core category which emerged from the analysis and coding procedures and represented the central phenomenon around which all other categories are related (Strauss & Corbin, 1998). The core category, representing the main theme of the students' stories of self-disclosure, is *Lifting the Veil*, which described self-disclosure and revealed factors and influences that encouraged or inhibited students' decisions to reveal or conceal a mood disorder. This core category described the *Self Disclosure Decision Making Process* that participants' experienced as they chose when, how, and to whom to disclose their mood disorder as well as the act of *Self Disclosure* itself. The *Self Disclosure Decision Making Process* describes students' Motivation for self-disclosing or *Lifting the Veil*, and the Conditions which encouraged their self-disclosure. For some participants, certain Conditions inhibited their self-disclosure resulting in non-disclosure and concealment of their identity as people living with a mood disorder. The act of *Self-Disclosure* is described through its five subcategories: Context (setting or situation), Approach (aspects of a personal style, or approach), Method (in person or via email), Characteristics of Disclosure Recipient, and Outcome of disclosure experiences.

The core category is comprised of two categories – *Self Disclosure Decision Making Process* and the act of *Self Disclosure* itself. The following section describes these categories and their respective subcategories which combine to create *Lifting the Veil*.

### *Self Disclosure Decision Making Process*

The initial category of *Lifting the Veil* is the *Self Disclosure Decision Making Process* which describes the participants' Motivation for self-disclosure and the Conditions that encouraged or inhibited their self-disclosure.

#### *Motivation*

Motivation for self-disclosing a mood disorder varied from participant to participant. Reasons for self-disclosing included: to explain behavior, to receive support and academic accommodations, to build and enhance relationships, and to educate and raise awareness for mental illness.

Amanda explained that her Motivation to self-disclose to her friends on campus was to explain to them why she doesn't always participate in social gatherings. She said, "I'm happy to say there is a reason I am the way that I am. Sometimes you have to disclose so they don't get the wrong impression." Felicity shared similar Motivation for self-disclosing to her peers:

It can help for someone to know because I'm sure there have been times when my friends have thought that I was ignoring them because I didn't like them, or when they asked me to go out that I didn't want to hang out with them. But a lot of times it's because I'm just not feeling like I'm up to it because I just feel so bad. I don't want to lose friends, so if I explain to them that I have

depression and I'm not out to hurt them, that helps me feel OK that they're not going to leave me.

Alex's Motivation for self-disclosing to her boyfriend was to help him understand her better and to recognize that her unpredictable moods were the result of her bipolar disorder. She shared, "It helps him to understand the patterns that arise so he won't react so readily in anger. He is more understanding. It helps the close people in my life recognize that this is because of an illness." In addition, Billy said that his Motivation for self-disclosure was to explain behaviors that people often misunderstood without having knowledge of his mood disorder. He said, "Most of the time the situation is me trying to explain why I did something that didn't seem right and wasn't explained. Without adding that extra information in there, they wouldn't understand."

X, June, and Felicity were Motivated to self-disclose their mood disorders out of a need for support. X talked about self-disclosing to peers to gain their support. He said, "With friends and peers, not only do I tell them out of a feeling like I needed to disclose my illness, but also I told them for support. I need to get things out of my head and stop trying to battle it on my own. I need to bounce thoughts off with another person." June shared that her Motivation to self-disclose to faculty was to gain their support and understanding and to "explain why there are gaps in my performance." She said:

Depression provides the context where those gaps can be explained . . .

Whether it's not coming to class every time, not turning something in on time, whether it's struggling with a paper or a project, where knowing that I have

depression provides a context for my behavior as opposed to I'm just a flake, I'm irresponsible, I'm not doing my work. Usually, my choices to disclose to faculty are driven by that.

Felicity also expressed a need to self-disclose in academic settings and described her Motivation for revealing her mood disorder to faculty. She said:

I'll tell a teacher what is going on. I feel that if academically I can't perform up to my normal standards and if I explain to them what is going on then maybe they'll understand and give me some kind of accommodation. I want to have the same opportunities to do well as other people.

David shared that his Motivation for self-disclosing bipolar disorder was to build and enhance relationships. He explained, "If I can open up to them then it allows us to have a better relationship because it allows me to feel that I can be more open. Self-disclosure results in a better relationship with other people, a closer relationship." And June expressed that "self-disclosure is a necessary component of having an intimate relationship with a friend or partner."

Amanda, Billy, David, and X shared a desire to educate others and raise awareness for mental illness and reported that this desire was their Motivation for self-disclosure. Amanda explained:

The only thing that would motivate me to disclose is to educate people. For people to know that they know someone firsthand who has it and isn't really severely affected by it . . . I feel like I don't fit the profile very well. I feel like disclosure would help. Knowing people like me have it could help people be



less judgmental in the future . . . I'm proof against the stereotypes and there are a lot of people like me. So, I want people to know that.

Billy described his Motivation to educate people about mental illness and to decrease potential misconceptions about people with mental illnesses. He talked about self-disclosure as a vehicle to inform people and to increase tolerance. Billy said:

If I can explain it to somebody and have them understand it, then maybe the next time they won't be as judgmental about somebody with one of these things because they understand it a little. I guess it's for the next round. If I can feel like I can inform somebody about it and give them an understanding, then the next time they deal with someone who has that, they will be fair and they won't be quick to stigmatize. They'll actually come to the table with an open mind about it.

Through his self-disclosures, David hoped to "raise awareness" and "make a difference in the way that people who are mentally ill are seen."

X was committed to influence social change and to combat mental illness stigma by educating others about the experience of having a mental illness. He said:

Until there is no stigma, I'm in a position where I do have the support and I can disclose these things . . . That is what I'm supposed to do and this is part of what I'm here for to help people with mental illness and help create a society where everybody can live to their own potential and getting people the help they need and there is nothing to be ashamed of.

X explained how self-disclosure was an opportunity to "humanize" the experience of having a mental illness:

I feel that a lot more people should disclose the fact that they're dealing with mental illness because it helps to humanize those conditions. When I disclose and actually humanize it, people actually come into contact with someone who actually has these problems and it can help them see it as tangible, it's not abstract anymore. And when you get to know someone and you actually begin to care about them, you can't help but to understand their plight and where they're coming from. That is how I believe disclosure humanizes it because it helps take away the abstractness.

### *Conditions*

Participants reported various conditions necessary to facilitate their self-disclosure process. It was important to have established some sort of rapport with the recipient of their disclosure; how well they knew the discloser recipient and whether or not trust had been established were two conditions that needed to be met before a participant was confident and comfortable with self-disclosure. The participants also shared that having a degree of control was a necessary condition of self-disclosure. Control was expressed in two ways: (a) control over symptoms of illness and (b) control over who has knowledge of their identity as a person with a mood disorder. Another condition of self-disclosure was mutual disclosure. Participants were more likely to self-disclose their mood disorders to people who were willing to reveal something personal about themselves.

Participants expressed concern that as a result of their self-disclosures, they would be defined only as people with mental illnesses, overshadowing other important aspects of their identities. To avoid this, it was important to allow people

to get to know them before self-disclosing their mood disorders. Amanda explained, “It takes me getting to know someone and knowing that I can trust them and that they know me beyond the diagnosis. This way, they don’t judge me because of it. I want them to know who I am before I give them a label that they might assume things.”

Felicity described a similar concern:

It’s important for people to get to know me as a person because there is more to me than just being a depressed person and I don’t want to be defined by that. I don’t want that to be their sole way of identifying me. There is way more to me than just this and I didn’t choose for this to be a part of me; there are other aspects of my personality that I try to make stronger and make more obvious . . . It’s easier for me to disclose this to other people who have seen my other traits. Not to people who don’t know anything else about me. By saying that I’m depressed, they might define me as the depressed girl and I don’t think that’s my one characteristic that should define me.

Billy expressed willingness to self-disclose after he becomes “pretty close with somebody.” He explained, “I would need to feel like my disclosing that I have this illness wouldn’t make them want to be my friend any less. I would need to feel that by telling them, I wasn’t weakening our relationship.”

Participants explained that having control over symptoms of their mood disorders was an important prerequisite for self-disclosure. Control over symptoms improved Olivia’s ability to communicate her thoughts. She shared:

People need to at least have a degree of control over their illnesses and medication or therapy so that when they disclose to people, they can disclose

in a concise manner and can actually verbalize what they have. Because I know when I can't control my symptoms, I have a very hard time communicating verbally and expressing myself.

For X, self-disclosure was more likely to occur when he felt he had control over his depression. He said:

The more control that I feel over my illness and the more control I feel over myself, the more likely I am to disclose because I feel like I can better control that interaction when I do disclose to someone. Before, when I lacked that control, I thought that if I told someone then you know, there would be this flood gate of emotions – either crying, anger, things of that nature– so I felt that there had to be mental safeguards in place.

Self-disclosure was “easier” for David when he felt control over symptoms of his bipolar disorder. He also reported increased self-confidence in disclosing his mood disorder. He shared:

It makes it easier for me to disclose because I have self-control over my thinking and my behavior and so forth. I don't worry as much when I disclose to other people that I'm bipolar because I understand what is going on inside me. Because I feel like I have some control over that, it gives me confidence to go up to somebody and explain to them that I am bipolar.

Alex talked about how having control over symptoms of her mood disorder was a “positive influence on disclosure.” She described her self-disclosure process both when she felt control over symptoms and during times when she was not in control.

She shared:

When I didn't have control, I didn't disclose to people because I didn't have a hold of the situation at all and it was pointless to talk to people because they weren't going to understand because I wasn't clear about what I was talking about . . . Now that I'm in control, I'm just hugely more comfortable talking about it and I'm more comfortable about my behaviors and it's not my illness and I own it now. Before it owned me.

Some participants reported that when they were in control of symptoms of their illnesses, they often chose not to self-disclose because they aren't in need of support. Felicity explained, "If I feel like I'm in control over everything that is going on with me, I won't disclose anything because I won't have a need to." Billy said, "If I'm feeling good and healthy, I'm probably less likely to disclose because I'm less likely to think of me like that – like someone with an illness. I'm less likely to disclose because I'm not reminded of it." And June said, "If my illness is under control to the point that I can structure my life and I can make my life function to the way I want it to function, then why self-disclose? The less in control I am of my illness, the more important disclosure becomes."

Participants also reported that they needed to control who had knowledge of their mood disorder. Amanda said, "I want to know everyone who knows and I want to be the one who decides who knows, so I want to have full control over that." And Alex remarked, "I want to be the only one to dictate that this person knows and this person doesn't and this person knows a little and this person knows a lot." Alex elaborated on the importance of having this control:

I want to know first of all, who knows. I want to decide. I don't want to be talking to someone on the phone and all of a sudden it's really obvious that they know, only I didn't tell them and I didn't know that they knew. The other thing is that when you repeat a story, you never get it exactly right and you can't answer any questions because you don't know anything else except for what was in the story. Whereas, if it were your story, you're going to get it right because it's yours. You can't get it wrong. And if someone has a question, you can answer it because it's your story, you know all the answers. So, it's easier.

Amanda emphasized the importance of establishing trust with people to whom she disclosed her depression. Trusting recipients of her disclosures to respect her privacy and maintain her confidentiality was an important condition influencing her decisions about self-disclosure. She explained:

Since I choose person to person who I tell, I want to know that if I tell them, it's not getting anywhere past them. I would hate to tell somebody and them go tell somebody that I don't want to know. I'm trusting them with the information I'm giving them . . . I don't want to know that someone else found out from someone else because I'm just very picky with people who I want to know. I don't want certain people knowing things and that is the reason why I don't tell them.

Another condition of self-disclosure that participants reported was the concept of mutual disclosure. The participants were encouraged to self-disclose their mood disorders when people revealed their own experiences with mental illness or

something personal about themselves. X talked about how mutual disclosure facilitated his self-disclosure process:

When someone discloses to me, it can be mental illness or anything that I think may relate to a mental illness or any type of personal disclosure. Just anything that they would only reveal to a select group of people . . . If they reveal that to me, then I feel as though I am special in some way and so I'm more forthcoming revealing information about myself.

Mutual disclosure allowed Amanda to develop the trust she needed to feel comfortable with her own self-disclosure. She said:

If they start disclosing personal information about things, there is no type of information specifically, it's just anything that I know they don't want everyone to know about, they are trusting me with their information so they would be less likely to blow my trust and I would be more likely to talk about my depression.

Trust was an important aspect of mutual disclosure for Alex as well who shared the following:

If they can tell me something that they don't want other people to know, that helps because then I know that it's not just that I trust them and they're not going to tell anyone else, but they have the same trust in me. Just telling me something important that they need to talk to someone about but they don't necessarily want to talk about it with everyone. It's not telling me about a psychiatric illness necessarily. Just that we both know that we can tell each

other things and it's not going to change the relationship we have and it's also not going to end up going out to all people who we know.

The participants described how experiencing mutual disclosure with another person diagnosed with a mental illness created "common ground" (June) where people can "dialogue back and forth" (June). This encouraged the participants' self-disclosure process by increasing their "comfort" (David) and willingness to reveal their mood disorders. David described how this type of mutual self-disclosure gives him confidence to self-disclose:

If someone tells me in the first time I meet him or her that they're mentally ill, then I feel comfortable telling them that I am too. If they tell me that they're mentally ill, they're putting themselves on the line. They're putting some trust in me that I'm not going to make fun of them or that I'll think something badly of them. It's a willingness to be that open that I feel comfortable and confident about being open.

For Olivia, self-disclosure was "easy" with a person who had depression or showed signs of being depressed because she could "relate" to the experience. She said:

When anyone talks about depression or makes comments about being depressed or I can sense that they're depressed, I find it pretty easy to disclose. I think whenever someone is really stressed out or upset, I think it's very easy to disclose because we may have something to relate to when I say I'm bipolar.

Mutual disclosure encouraged June to self-disclose by helping her build connections with others and form relationships. She shared:



The people who also have depression or some kind of mental illness kind of dialogue back and forth where they will talk about their life and illness and I'll talk about mine . . . It makes it less of a big deal for me. It's something that could potentially create some common ground with someone else and it does create this point you have in common, this place that a relationship with people can develop from . . . The whole issue is that self-disclosure makes you vulnerable and if a person allows themselves to be vulnerable first, it makes it easier, it makes it a lot more comfortable.

Alex reported that mutual disclosure allowed her to better understand her own illness "because I feel like I can talk about a wider range of feelings and emotions and experiences." She went on to say,

By mutually disclosing, you can form a better understanding of your own illness because they have a different frame of mind than you do and by seeing where the parallels and differences are you can better define your own illness. So, it defines a better comfort level for me because they'll understand. The comfort level is that you can come back to them because they're battling the same kinds of problems as you are . . . It's kind of a mutual benefit.

Motivation and Conditions created the category *Self-Disclosure Decision Making Process*. The decision making process was the first of two categories that created the core category, *Lifting the Veil*. The second category, the act of *Self Disclosure*, is presented in the following section.

### *Self-Disclosure*

The act of *Self-Disclosure*, the second category comprising the core category *Lifting the Veil*, is described through its five subcategories including: Context, Approach, Method, Disclosure Recipients, and Outcome.

#### *Context*

The participants described particular settings and situations in which self-disclosure occurred. They preferred to self-disclose their mood disorders in private settings often with the door closed and shared that self-disclosure typically was a one on one experience with another individual. Amanda described the context of her self-disclosures:

Only in very private settings. Normally it's one on one, just me and another person. I very rarely disclose to more than one person at a time only because I feel like I need to be one on one with them. So it's normally in my house or in my dorm room. It would never be in a public setting.

Because of the personal nature of her self-disclosure, Olivia revealed her bipolar disorder on "an individual basis." She shared:

I never say it in front of a group of people. I'm not comfortable to let more than one person know at a time. I don't know why. I guess it's so personal that if I told a whole group of people then I might not know some of the people in the group as well as others and I don't know what they would think.

And I'm sure that some of them wouldn't understand what bipolar is.

Although X was willing to disclose his depression to more than one person at a time, the setting was usually in a small group that felt "intimate." He said:

I'll disclose even if it's a big group of people, but as the size of the group gets smaller and the intimacy level goes up, the amount of disclosure goes up.

Whereas if there is a big group of people, I'll say that I have depression, but I won't delve into all the details about what affects all that.

Participants expressed concern about maintaining their privacy when they disclosed a mood disorder. To ensure their privacy, participants often self-disclosed behind closed doors and in settings that felt comfortable and familiar to them. David explained his need for privacy:

I want to know at the very least who is listening. I like to know who is hearing me and it's easiest behind the closed door or one-on-one and just not in a crowded setting where other people who I don't intend to learn about my disorder, I don't want them to know unless I decide to tell them.

And Alex said, "I have to know that people I'm not comfortable with aren't going to just walk in the room or overhear the conversation. So, a comfortable setting where a door could be closed or locked."

Amanda and Felicity were most comfortable self-disclosing in the familiar surroundings of their residences. Amanda preferred to self-disclose in her "private space." She said:

It's always been in a quiet one on one conversation with a person. A personal conversation. I guess generally the door needs to be closed because that is generally what it takes to have full privacy . . . In my dorm room, so the door is closed, things are quiet, there is no one else around, I know no one else can hear me, and it's my own private space.

Self-disclosure often spurred emotions in Felicity and she preferred to self-disclose in the comfortable setting of her own apartment which offered her the option to “escape” if the disclosure experience felt overwhelming. She shared:

I want to be in a place where I’m comfortable and where I have a way to escape. If the person starts looking at me like I’m strange, I can get out of the situation fast . . . I usually talk to my friends in my own apartment where I can run into my room and start crying and close the door.

Participants also shared that privacy was important to them when disclosing to faculty. June said, “When I’m self-disclosing to a faculty member, privacy is nice and also being in a place where they’re not distracted . . . I really prefer to do in their office with the door closed because I feel like it’s private and I have their undivided attention.” Felicity was careful to maintain her privacy when approaching faculty:

If I have to talk to a professor about what was going on with me, if there was a big line of people behind me, I wouldn’t talk about it because it means that I would tell tons of people and not that one person. If it’s during office hours with a professor whose office door is open, then I feel like it’s not as private enough for me.

Participants shared situations in which they revealed a mood disorder to their peers and described the circumstances leading to their self-disclosures. Felicity spent time at Hillel and spoke about the first time she disclosed her mood disorder to her peers in that community:

I think the first time I told the friends was when we were eating at Hillel. I think we were sitting there and someone said they should just put Prozac

straight in the food because all the people there take some kind of medication, and we were joking about that . . . and I asked one of them if she was on medication and she was like “yeah.” Then I felt like it was OK for me to talk about it too because I knew that the person wouldn’t be judgmental toward me because they had a similar problem.

Amanda was compelled to self-disclose to two of her peers who found anti-depressive medication in her room. She shared:

I’ve had to explain simply because someone saw my Prozac on my medicine shelf and asked what it was. There are two guys who live upstairs from me who were hanging out in my room earlier this semester who I’ve been friends with for about a year who saw it and asked if the medication was mine. I said, “yeah, I’ve been diagnosed with depression.

### *Approach*

The participants described aspects of a personal style or approach to self-disclosure. Some preferred to ease into it very casually and others used a more direct approach. For Alex, the process of self-disclosure was gradual. She finally revealed her mood disorder to her friends after she engaged in several prior conversations with them about general feelings and moods that she was experiencing. She explained:

I would be talking for a couple of weeks about things that were bothering me and I would describe all the feelings but without having a name for it. Then, casually, I would just say that I’m thinking about going to see a counselor and then that would turn into another follow-up when friends would ask how that

went, and then I would say, “Actually, they diagnosed me with depression.”

That is how I ease into it.

Amanda approached self-disclosure to her friends in a similar way. She said, “I don’t really sit people down and say, ‘I want you to know that I’ve been depressed.’ It’s more like, ‘I’ve been through a lot and you need to know that.’ In the end, I say, ‘I’ve been diagnosed and I’m on medication.’”

Rather than easing into the subject, other participants preferred a direct approach to self-disclosure. Olivia shared:

The only way I can do it is just being very forward and blunt. I never know what to say to lead into it. So basically, when someone asks how I am and I’ve been having a bad day or I’ve been depressed that day, I say “I’ve been having a bad day” and they will ask why and I will say “I’m bipolar.” And it will be that simple because I don’t know how else to explain it or how to lead into it.

X used a direct approach to self-disclosure to initiate dialogue with others. He said, “I come right out and say, ‘I have clinical depression, this is why I’m feeling this way.’ I usually disclose my illness as a way to open up dialogue and get them to understand what it’s like living with depression.”

### *Method*

Participants identified two ways in which they self-disclosed. Some chose to reveal their mood disorder in person and others preferred to do it via electronic mail. Most participants preferred to self-disclose in person (Alex, Amanda, Billy, David,

June, Olivia, and X). For Felicity and Jennifer, however, self-disclosing via electronic mail was their preferred method.

Communicating in person was important for X because it allowed him to view non-verbal cues from the person to whom he disclosed his depression:

I like it to be face to face. I want to see the person. Over the phone, over email, in a letter, you really can't get the subtle nuances that I consider to be very important when you're discussing something with someone. I want to see your body expressions, your facial expressions. If it's over the phone or in a letter, I can't get that information.

Olivia preferred in person disclosures for similar reasons:

I prefer to do it in person because it's easier to communicate with a person when you're face to face . . . When it's in person, it's easier just because you can just wait and there could be pauses, whereas when you're on the phone, it's awkward to have a lot of pauses and in person, you can let the person think about how they want to react.

Billy felt more in control of the situation during in person disclosures. He felt he could explain himself more effectively when self-disclosing in person. He shared:

I would want it to be face to face talking. It doesn't allow for them to sit there and mull it over on their own and to figure out on their own what it means. I have to be able to control the situation so that I could tell them and then explain it and be the one to teach them what it means as opposed to them having time to think about it and getting the wrong idea. I think just being there with someone and talking about it allows me to show people that I am

still me and although this new information is out there, I'm still the same person.

As June described, in person disclosures allowed for more dynamic exchanges between people:

Because of the face to face, it's the most intimate way; it's not mediated through some sort of technology. It's just you and the other person. It makes their reactions a lot better and I think that even though you have the back and forth on the phone and on instant messenger, it's not as direct as the back and forth conversation you have when you can see someone in person.

Alex, Amanda, and David described the advantages of in person disclosure over using technology to mediate the self-disclosure process. Alex said:

I would never disclose on email or letter. Over the phone, it's too personal of an issue to do over the phone. I haven't done it over the phone yet. Definitely in person is a preferred method for me just because on instant messenger, things in everyday conversation are taken totally out of context because you can't hear voice fluctuation or tone or anything like that, so that is just out.

Same thing with email. On the phone, you can hear those things but you can't see the person's facial expressions or the way they use their hands, which is a big thing for me in describing the bipolar. I use my hands a lot to express.

Plus in person, it's more personal.

For Amanda, in person disclosure was important because it gave her an opportunity to see a person's reaction. She shared:



I hate on-line because you can't tell tone of voice, body language, eye contact, and stuff like that. Even over the phone, I don't think that I would ever want to do that because seeing the person and seeing how they react can tell you 100 times more than just hearing them or just reading a response or whatever else. A person's reaction is very important to me because I'll either see if they understand and have compassion or see that they need me to explain it more because they're jumping to the wrong conclusion and I can actually see it.

That makes a difference so it's always in person.

Because of the emotions involved in his self-disclosures, David preferred to reveal his bipolar disorder in person. He explained:

I prefer to disclose in person and not through email and not through chat rooms, but in person where I can see that person and see their reaction and also because of the nature of the subject, it's awfully hard because there is a lot of emotion that goes into disclosing to somebody because there is that emotion that goes into it and you can't share that on the computer and people can't see that.

Felicity and Jennifer described their reasons for preferring self-disclosure via electronic mail. Felicity said, "It's easier to write it. You don't see facial expressions that people have, so you can't really see the stigma." She shared that in person disclosure doesn't give her the "protection" that email offers:

If I tell someone in person, I feel vulnerable and I feel like I can get hurt more easily or I'll start crying and I might look stupid. You're putting yourself out there and you're not as protected from seeing what people's reactions are to

what you're saying and that is a big thing for me when I'm one on one with a person.

On-line communication gave Felicity more options to connect with others and seek support:

When I need to talk to someone and no one is around, I'll go on-line and see who is there and if someone I know, my boyfriend or a friend who knows about my depression problems is on and I know they don't mind talking to me, that is really helpful and I'll talk to them. And so when I'm on instant messenger, I'm getting the same fast response from the person, but I'm writing it and it's a lot easier for me to do.

Jennifer preferred to disclose on email because it gave her more control of the situation. She shared:

You don't have to talk about it. When I write, I'm just done with it. I don't know why it would make me nervous to say something. I guess because I don't want to talk about it. You can't control what you say. Once you say it, that's it. When you write, you can revise what you're saying.

### *Disclosure Recipients*

Participants looked for certain characteristics in people when deciding to whom to self-disclose their mood disorders. They described recipients of their disclosures as "trustworthy" and "nonjudgmental." Amanda felt that her disclosures would remain confidential among people who were trustworthy. She said, "Trustworthy people aren't going to talk behind your back, they're not going to tell people you don't want to know . . . They would never go behind my back and say

anything, which is a huge thing for me.” Felicity valued people who were “caring, supportive, understanding, and nonjudgmental.” Olivia said, “I’m looking for honesty and openness. People have to be friendly and attentive . . . I feel more comfortable telling people who have time to listen.” And Billy shared, “I need to feel that they are capable of understanding the illness, even on basic terms. People that I felt that I could trust who I didn’t have to worry about judging me.” Tolerance and understanding were also important to Amanda who said:

The more nonjudgmental a person is, the much more likely I am to tell them because someone who is nonjudgmental takes things as they are and moves on from there. They don’t go in with assumptions. They don’t go in with prior expectations of how things are . . . They would never let my title of an illness overshadow any attributes that I actually have.

When asked to describe characteristics that he sought in a disclosure recipient, X identified a specific demographic of people with whom he felt most comfortable disclosing. He said:

Usually the people that I disclose my illness to fit a certain demographic. They are usually female and ethnic; you know, for example, Hispanic, Latino, Asian, Black. And the people I usually do not disclose my illness to are usually males and White males. I think heterosexual males are the people I usually have least in common with in terms of the way I feel in regards to society and the way that society stratifies. You can’t usually see eye to eye and I think that is why.

He went on to say:

The people who I don't really disclose my illness to are males, White males, heterosexual males, and these are the people who generally aren't good at expressing themselves, feeling emotions interpersonally, so those are the people that I generally don't disclose my illness to because I find that it takes a lot more work to get them to understand where I'm coming from, whereas minorities and women, these are people who occupy different sections of society and need to be understanding.

### *Outcome*

Participants described outcomes of their disclosure experiences. They also spoke about the resulting outcomes when they decided not to reveal their mood disorders. The following section describes the participants' self-reported outcomes for both self-disclosure and non-disclosure.

The participants' self-reported outcomes of self-disclosure were positive. They overwhelmingly felt a sense of relief after self-disclosing a mood disorder. Alex explained, "It feels good. It's cleansing, relieving . . . I really enjoy being able to get it out and being able to vent and talk about it out loud. Most of the time, I have to work everything out in my head, to myself. When I finally have the chance to talk to someone, it's nice to have a dialogue." And Felicity shared, "Sometimes just getting it out feels like you're really relieved and less stressed out just by saying it." For Amanda, self-disclosure "feels like a weight has been lifted off." She said, "When I disclose, it's a relief. It makes things easier because people understand me more." X described self-disclosure as a "source of healing." He said:

It was a way to reaffirm myself and reaffirm that these aren't things to be ashamed of . . . I realize that I'm actually very strong and me coming to grips with my illness and disclosing my illness is not a sign of weakness, but a sign of strength . . . I feel that disclosing my illness helps me connect to other people and my illness itself helps me see things that other people take for granted."

Olivia and David spoke about how self-disclosure helped them connect with others and enhanced their relationships. As a result of self-disclosure, Olivia reported feeling better about herself and "more comfortable and more relaxed." She shared:

Disclosure signifies that I'm opening up much more to a person. And I think whenever I do that with a certain individual, it kind of brings our friendship closer because of opening up so much. I think it's healthy just to be open . . . For some reason now that I'm disclosing to people, it correlates with confidence and now I'm having more confidence.

And David explained:

Disclosing takes a little bit of the load off my shoulders . . . It makes it easier for me to be open with somebody and not constantly be careful about what I say with the fear that I might say that I'm mentally ill and then have to deal with the consequence at that time. It makes having a relationship with someone, a friendship or even a professional relationship, a lot easier for me.

Participants also shared outcomes when they experienced non-disclosure and decided to conceal their identities as people with mood disorders. Participants carried heavy burdens keeping this aspect of identity hidden from others. Amanda shared:

It means basically keeping a big part of my life hidden. It's like keeping a secret that's really what it is . . . It puts a big burden on me to constantly decide whether someone is going to know the truth or if I'm going to continue to keep things from them.

And Felicity said, "This is a part of me . . . If I hide that from them, then I feel like I'm hiding a part of myself and I'm not going to feel totally comfortable or happy or like I'm being honest unless I do say something." For X, concealment of his depression left him feeling "alienated and alone." He shared:

It's alienating because you feel like you don't have anyone to talk to, you feel so alone, you feel as though no one will understand you . . . When I feel I can't disclose my mental illness and I can't get the support I need to help work past it, it makes me feel very alone.

The act of *Self-Disclosure* was understood through exploration of Context, Approach, Method, Characteristics of Disclosure Recipient, and Outcome. Together *Self-Disclosure* and the *Self-Disclosure Decision Making Process* created the core category *Lifting the Veil*. The remaining five categories, *Receiving Diagnosis*, *Constructing an Illness Identity*, *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality* are presented in the following section. These key categories complemented the core category of *Lifting the Veil* as factors that contributed to its development.

## Key Categories

### *Receiving Diagnosis*

*Receiving Diagnosis* of bipolar disorder or major depression initiated the self-disclosure process for each participant. *Receiving Diagnosis* is described through its three subcategories: Reaction, Type of Disorder, and Coming to Terms. The participants' individual experiences and responses to their diagnoses are described as a "relief" and an "explanation or validation" for behaviors and feelings that formerly were misunderstood, contributing to an increased likelihood that they would disclose their mood disorders. Some participants described feeling disbelief or "denial" about their diagnoses which led them to conceal their identities as people living with mood disorders. For some participants, Type of Disorder was significant. Three participants who were initially diagnosed with major depression now identify as having bipolar disorder after receiving a new diagnosis from their psychiatrists. They described how self-disclosure was different for each mood disorder. Coming to Terms with a diagnosis was developed and influenced through the reactions of family to diagnoses, the participants' enhanced personal understanding and awareness of their diagnoses, family history of mental illness, and treatment plan.

### *Reaction*

Participants described their reactions to receiving a diagnosis of major depression or bipolar disorder. Reactions were both positive and negative, ranging from relief and validation to disbelief and denial. For some participants, *Receiving Diagnosis* gave them an explanation for their mood fluctuations and provided a language to use to describe symptoms which made self-disclosure "easier and more

concrete” (Amanda). David explained how his diagnosis encouraged his self-disclosure.

I didn’t have an explanation for all these problems that I’ve experienced all my life, so the diagnosis was helpful . . . It’s significant because first of all, it gives me something to attack and to try and treat and it makes my life a little more clear. So I had the information, I had a diagnosis, so I had some support. In the long run, that made me feel more comfortable disclosing.

Before, I didn’t self-disclose because I didn’t have a diagnosis to disclose. I have a diagnosis and it calls me to self-disclose more often.

Receiving Diagnosis served as an explanation for Amanda, validating her struggle to understand her moods and behaviors.

I feel like it’s been a good thing to have the diagnosis because before I knew, I felt more hopeless. I had been battling this for like seven or eight years and not knowing what was driving me to do the things I did or to want to do the things I did.

Before receiving a diagnosis, participants found it challenging to disclose “a whole list of problems” (Amanda). Olivia commented that after being diagnosed with bipolar disorder, “I could actually say I have bipolar instead of listing all of these symptoms that I don’t understand.” For Billy, receiving a diagnosis of bipolar disorder was “the turning point” giving him “something concrete to blame stuff on.” He went on to say,

Receiving a diagnosis gives you a concise way to explain in general what your



life is like, your problems and stuff like that . . . It makes disclosure easier because you don't have to go through the process of explaining every little thing, basically listing all the symptoms. Having a diagnosis has made it easier to disclose because if I didn't have one, I think I'd be less likely to go into all the characteristics of that illness. If I know a term for it, then I think it's easier.

Amanda shared that receiving a diagnosis of major depression helped her understand herself better because it explained behaviors that she struggled to understand for years. She shared,

It has a textbook definition, it's not just some random thing, so I guess seeing the doctor and being diagnosed made me more likely to tell people that I have symptoms and what it's like . . . it's an actual disease that comes with symptoms, so it makes it easier to disclose because it's an actual thing and has a name. It's almost comforting that there is an explanation for it.

Alex described feeling relieved after receiving an initial diagnosis of major depression which was later changed to bipolar disorder. Like Amanda, the diagnosis gave Alex a context for her behaviors and helped her understand them better.

I felt like it was a relief. That when I was getting so angry or so sad that I couldn't control it, it wasn't abnormal because other people had it too and there was a diagnosis for it . . . I think being diagnosed helps a lot because I don't feel as strange anymore . . . It was a relief to get diagnosed and not to think of it as something in my head.

Receiving Diagnosis was not always a positive experience. Some participants reacted to their diagnoses with denial and disbelief. Olivia described her reaction to being diagnosed with bipolar disorder in the following way. “I just attempted to deny it and I associate the label with being crazy and I didn’t want to be crazy . . . It was just really difficult for me to all of a sudden be given a diagnosis that I didn’t really want to accept.” At first, Olivia didn’t feel comfortable telling anyone about her diagnosis because she didn’t accept it herself. But at the time of the study, three months had passed since receiving her diagnosis and she commented that she was becoming more comfortable with the diagnosis and felt more open to disclosing to others. She explained that her participation in this research served as an intervention which encouraged self-disclosure. She said, “I guess it was in the past month that I’ve started telling other people and it’s partially because of these interviews to be honest.” Despite her initial disclosures, Olivia is still not yet completely comfortable with having nor disclosing that she has bipolar disorder, largely due to the stigma surrounding mental illness. She shared, “I’m still going through a process of denial. I still feel uncomfortable telling people that I have bipolar and I don’t know why. I guess it’s because people associate bipolar with being crazy.”

Like Olivia, X initially denied his diagnosis of major depression. He said, “I didn’t accept my illness. There was a period of denial where I thought there is nothing wrong with me, I can handle this. What kept me from self-disclosing was my own self-denial, my own anxiety, and what people would think of me.” When X shared materials for document analysis (Appendix I), he described his feelings about having depression in the following quote: “I felt very angry at the world because I

was like why me? Why did God do this to me? Why can't I just exist like everyone else?" X shared that he began disclosing his depression to other people "when I started to accept it myself." When asked what influenced his acceptance of the diagnosis, X spoke of "greater self acceptance, more awareness of my illness, and better understanding of my illness." X shared that the process of accepting his mood disorder entailed "getting past the grief" which allowed him to self-disclose and to "reaffirm myself and reaffirm that these aren't things to be ashamed of."

June shared that she experienced "initial resistance to read this as depression" which led her to avoid self-disclosure. She said, "At first I didn't really have a language. I hadn't dealt with it and I would say that my self-disclosure in any meaningful way started after I tried to wrestle with, 'OK, I'm depressed, what does that mean?'" June described her early disclosure experiences as "horrendous because I was at a very different place with understanding my illness where there was this denial going on. I didn't even want to acknowledge that I had a mental illness." As June has become more comfortable with her diagnosis, she commented that "disclosure has become easier just because I've become more comfortable with depression." Overall, June now was open to self-disclosing and had experience telling family, friends, and faculty. On the other hand, Jennifer had more limited experience disclosing depression because she is "embarrassed by it and a little ashamed." She had not shared her diagnosis with anyone on campus and commented that her participation in this research and her disclosure to the researcher was an "initial testing ground" introducing her to the self-disclosure process.

### *Type of Disorder*

Felicity, Alex, and June initially were diagnosed with major depression and later rediagnosed with bipolar disorder. June did not describe self-disclosure differently for each diagnosis, but Felicity and Alex made several comments about how their new diagnoses of bipolar disorder were distinctly different from depression and how this difference impacted their decisions about self-disclosure. Alex explained:

Depression was never really that hard to disclose because I think at some point, everyone is depressed, so it was easy to say, “yeah, I’m depressed” or whatever. Bipolar is significantly different. When I first found out, I was embarrassed and so I didn’t want to tell people and I didn’t agree with the diagnosis. So, if I did tell someone, it was quickly coupled with “but I don’t think it’s true.” So, in the beginning, there was too much unknown for me and also, it was embarrassing and it was hard.

Felicity described the distinction between the two disorders and how disclosure has changed for her since being diagnosed with bipolar disorder. She shared:

It’s less of a big deal for me to say that I have depression than it is for me to say that I’m bipolar. Just because I know what a lot of people think about people that are bipolar – they think they’re just crazy. When you think about what crazy is, that is what a lot of people think of . . . The fact that it is called a severe mental disorder, that is what scares me . . . So with bipolar, people just think of it as more of a big deal and with depression people play it down a lot and just think that everybody’s been depressed in their life before.

These findings underscored the pervasiveness of mental illness stigma and revealed how individuals with mental illness - in this case, Felicity and Alex conceptualized their mood disorders and distinguished levels of stigmatization associated with particular diagnoses. Alex commented that “society acknowledges depression as an incident in life, it’s so common that people don’t take it seriously. But with bipolar, it’s going to sound more serious than it really is and define you as a person in society who should be in a mental ward.”

### *Coming to Terms*

Participants described a process of Coming to Terms with their diagnoses which involved developing a greater acceptance of self with respect to disability. Accepting their diagnoses led participants to feel more comfortable and willing to self-disclose their mood disorders. Family reactions to their diagnoses, increased self-awareness and understanding of illness, family history of mental illness, and participation in a treatment plan influenced this process.

*Family reaction.* Several participants reported receiving positive messages, motivation, and support from their families which helped them come to terms with their diagnoses and begin to accept the reality of living with mood disorder.

Amanda described the proactive messages she received from her immediate and extended family and the initiative they took to learn more about depression. She shared:

Everyone was happy because we knew what it was and we knew how to treat it. That’s really what it was. I don’t think anybody was embarrassed by it . . . By the time I started showing symptoms of something and nobody really

knew what, everyone bought books and that was my family's way of coping with it – to go and read. And I was textbook depressed. I had every single symptom blatantly. So no one was surprised, and everyone was relieved that now I had a diagnosis and there were steps to curing it or making things better. It's more like once you identify a problem you know how to solve it. So they were happy that we were able to identify it. It made it easier for them to understand it, especially because they took the initiative to learn more about the illness . . . I feel really lucky because my family has been good about it, they've been supportive.

Olivia's mother also showed her support by reading books to learn more about bipolar disorder and relate to her daughter's experience. Olivia said, "Since I disclosed to my mother, she is reading all these books on bipolar and she is very involved so she is being more supportive rather than denying it and that helps me accept it too." Alex's mother took an active part in her daughter's treatment plan. Alex described her mother's support in the following way:

My mom has always been highly invested in our relationship. She calls to check up and she was there for the first visit with the psychiatrist and so she knew what was going on and she was the one who suggested it. She cared enough to want to get me a solution that would work. Her involvement has helped me understand things better.

In addition to receiving positive messages about their diagnoses, families provided motivation and support to these students to self-disclose their mood disorders. Billy said:

Most of the reason why I'm comfortable and open disclosing to people is because I don't think I'm a freak and the only person in the world who is feeling those things and that comes from the way my family treated it – as a health problem and lots of people have it.

And X described how his parents' support reaffirmed his sense of self and created motivation to self-disclose his depression. He shared:

When I disclosed my illness to my parents, they helped reaffirm all those qualities that my depression was starting to mask. It came at a time when I really needed that support and that reaffirmation of my character and it helped that they saw me as a complete person and didn't let my diagnosis taint the other components of my character. It helped me get a clearer picture of myself, which then in turn helped me to be able to deal with my illness and helped me relay my feelings to other people. That helped disclosure.

X's parents taught him that depression is “not anything that you need to be ashamed of or that you should feel bad about in any way because it's nothing that you can control.” X reflected on the support and understanding he received from his parents and said, “It gave me the self-confidence I need in order to disclose my illness, in order to feel confident in who I was as an individual. Their support made me not to be fearful of having depression or disclosing.”

Each of the participants in this study identified messages about mental illness that they received from family as influencing their ability to come to terms with their diagnoses and to self-disclose their mood disorders. However, not all messages were positive and encouraging, as Felicity, Jennifer, and June explained.

Felicity described her parents' reactions to her diagnoses and their influence on her self-disclosure process. She said:

When I was diagnosed in high school, my parents knew what it was, but my dad still wouldn't call it depression or say that I was a person with depression. He basically said that I was going through a bad period and stuff like that. He wouldn't say the actual words . . . When I was diagnosed with being bipolar over the summer, my dad, there is no way that those words will ever come out of his mouth. And if I say something to him about it, he still doesn't believe it. And my mom I guess sort of believes it, but I think it's a way bigger deal to them than depression. For them to admit that I have bipolar is a lot harder for them. Because of the way that I've seen them react to the diagnosis of bipolar, that totally gives me an idea of how people are going to react if I tell them about it. If it's my family that is reacting this way, how are people who I'm not even close to going to react? So, I still won't tell a lot of people and I've never told a teacher ever before that I have it.

Felicity went on to describe messages she received from her parents about mental illness in general which were largely influenced by the stigma surrounding these disorders. During high school, she specifically was instructed not to talk about depression with anyone outside of her family. This created dilemmas for her, especially when interacting with friends. She shared:

My parents told me not to talk to my friends about depression or teachers or anyone else out of the family . . . I wasn't allowed to talk about it outside of the family so I was getting these mixed messages about it being normal and



being crazy. I tried to hide a lot of stuff from friends making it hard to be honest and open. I would make up reasons why I was sad.

Felicity received direct messages about self-disclosure from both her mother and father. Through those messages, she was discouraged to self-disclose her identity as a person living with a mood disorder, creating an internal struggle to come to terms with her diagnoses and contributing to a sense of guilt whenever she decided to reveal her illness to others. She described her father's reasoning for discouraging her disclosures:

My dad was like, "keep it quiet, don't tell anyone about it." He works for the government and they ask about your psychological history and I think he is worried about me getting a job and stuff . . . It's OK to be sick, physically sick, but mental stuff, that's not really OK to admit . . . My dad thinks that other people in the world view that as more, that it has a stigma attached to it more than physical illness . . . I think my dad just wants me to be able to be on an equal playing field with everyone else and I don't think he wants me to have things that are going to change the way that people are going to think of me.

Felicity also shared that her mother discouraged her to self-disclose to people she was romantically involved with. She struggled to reconcile those messages she received from her mom with her own desire to be open and honest with her boyfriends.

Felicity said:

My mom always tells me not to say anything to my boyfriends because it's too stressful and they might feel like it's their responsibility to make me

happy all the time. But I feel like it's the opposite. I feel that I should say to them after awhile that this is what I have because I don't want them to have to feel like the reason why I'm always upset is because of them . . . Her telling me that made me feel that that's a bad part of me and I can't really tell people because it stresses them out and I actually have felt that in my life. I actually feel bad by telling someone else. I internalized that from her so that affects who I tell, or it affects when I tell someone.

Unlike Felicity, Jennifer did not receive direct messages from her family about their views on depression but she did speak of her family's indirect influence on her comfort level and willingness to disclose her depression. She shared:

After I was diagnosed, we didn't talk about it at all as a family . . . If I had brought it up then, I think they would have talked to me about it. I just don't think that they wanted to be the first to say anything. It made me perceive that my behavior was making them uncomfortable . . . This is actually the first that I ever thought about that. And maybe it is impacting me because if I want to talk about it, I'll wait for the other person to go first. Maybe I'm doing the same thing that my parents did – making sure that someone else goes first so you can make sure that everyone is comfortable with the conversation and no one is going to get upset and no one is going to get angry or embarrassed.

June talked about her mother's approach to dealing with her diagnosis, how she perceived it to be negative and how it impacted her self-disclosure experience. She said:

When I was diagnosed, my mom was on a mission to find out what was wrong with me and it was phrased in that way that having some sort of abnormality in the way your brain works is equated with wrong . . . At first, these things inhibited me from disclosing and they still exist in the back of my mind to some degree.

Family messages, reactions, and norms about mental illness influenced self-disclosure for the participants and impacted their ability to accept their diagnoses. The direct and indirect messages they received from family were both encouraging and disappointing and influenced the participants' process of coming to terms with their mood disorders.

*Self-awareness/understanding.* By conducting research about mental illness through personal reading or taking classes in psychology or related subjects, participants sought to increase their own awareness for, and understanding of, their mood disorders, helping them come to terms with, and accept their diagnoses. David explained:

I need to have a good understanding of the disorder I have. A good understanding of what I have both from a personal standpoint but also from a clinical standpoint in the sense of having read books on psychology and books on bipolar disorder so I have a good understanding of the disorder from using those resources plus my own experiences.

And Amanda said, "After reading more about the illness, I understand it more. It makes certain instances easier to understand."

Billy talked about how becoming more informed about bipolar disorder impacted his willingness to self-disclose. He shared:

I've become more informed since I've been diagnosed and it's being more informed that makes me a little more comfortable to disclose because I think I know enough about it that I could explain it to somebody . . . Over time I learned more and so now I think I can sit down and explain to somebody in less than a minute what the illness is. I'm more willing to disclose to people as my knowledge increases because it's easier for me to explain to them what the illness is.

Alex described how her increased understanding about her mood disorder helped her agree with and identify with her diagnosis, leading to more positive disclosures. She said:

I completely agree now. Especially after doing more research. Before, I didn't agree at all. So I started to do research on my own and really started to identify . . . I feel more confident going to someone and not feeling like I'm a total mess. I'm able to make more succinct and more effective explanations to people rather than before, people wouldn't understand and would be totally lost about what I was talking about.

Alex went on to say, "As I become more and more comfortable in my ability to control the disorder and my ability to understand the disorder, I think I'll disclose more and more."

X read books and articles to better understand depression and to develop “tools” to help him convey his thoughts more clearly and succinctly when self-disclosing to others. He shared:

Basically, the knowledge and understanding of clinical depression in and of itself and how it affects my life gave me the tools to better articulate my illness . . . The greater awareness of my illness allows me to better understand my illness in terms of how I relate to myself so that affects my disclosure being that I am better able to articulate my feelings, my moods, how my illness affects me . . . Before, when I didn’t have those tools, I didn’t have those skills, disclosure could turn into a very awkward situation where neither one of us really understood where the conversation was going.

Felicity cited academic courses that helped her understand depression and overcome fears of becoming a target of stigma. She said, “I’ve taken psychology classes and I understand depression more now and I’ve realized that if you have depression you’re not what people call ‘crazy.’ So it’s easier for me to talk about it with certain people.”

Of all the participants, Olivia was most recently diagnosed with a mood disorder (just three months prior to her participation in this study) and expressed difficulty coming to terms with her diagnosis and revealing it to others. She explained, “It’s hard to disclose to people and articulate for them what my symptoms are and explain clearly why I’m bipolar because I’m still unsure how this happened and what really triggered it when I don’t know myself.” Olivia went on to say, “Once

I find out more and do my own research on it, it will be easier to disclose. I think I'm going to open up more as I learn more and as time progresses."

*Family history.* Six of the nine participants (Alex, Amanda, Billy, Jennifer, X, and Felicity) revealed a family history of mental illness and described how this knowledge was positive and helped them come to terms with and accept their diagnoses and even encouraged their self-disclosure process. Billy shared that his maternal grandfather had a mood disorder and eventually took his own life. Billy's family history validated his diagnosis by showing him that he was not the only one "out there, with issues." He shared, "It makes it easier to disclose because I have some more proof. I think it strengthens my disclosure because I can say not only did the doctors diagnose me, but these people in my family had it too. It makes my argument more valid."

X's mother has major depression and extended family members have depression and bipolar disorder. His knowledge of the genetic predisposition to his diagnosis of depression relieved his feelings of guilt and blame for somehow bringing on the illness himself. X said:

I realize that there is a genetic component to it and it's not my fault, so when I disclose, there is not that apprehension that it's because of something that I've done wrong to cause this. It just took away that portion of it that I thought was a moral flaw on my part . . . When I go to disclose it, there isn't that little voice in the back of my head telling me that it's all my fault because it's not.

Felicity shared that her family history of mental illness consists of both parents having depression and anxiety and three of four sisters who also struggle with

depression and anxiety. Felicity and X share a similar philosophy about the cause and nature of mental illness. Felicity explained:

Since I've seen it around me so much, I don't feel like it's a big deal anymore. I see it as a sickness, a mental illness, and something that I might have a little bit of control over but it's a genetic thing and I see it as something that I can't help and that makes me feel like there are times when I have to tell people because I can't help it. Just like if I broke a leg or an arm, I would need accommodations for that and I see this as an illness and I need accommodations also.

Although Jennifer rarely discussed her depression with anyone and had not disclosed to anyone on campus, she did speak about the role of family history in helping her adjust to her diagnosis and recognize that she was not alone. She shared that her two sisters also have depression and, like Jennifer, received their diagnoses during their adolescent years. Jennifer said, "We don't bring it up that much because we just don't talk about this kind of thing in our family. But when we have talked, we say how interesting it is that three sisters from the same family have it. It helps me get used to it knowing that I'm not alone."

Amanda shared that disclosure was "easier" for her since learning that her sister and paternal uncle both have depression. Knowledge of her family history helped Amanda realize that "mental illness is probably more prevalent than I thought." When discussing the influence of family history on the self-disclosure process, Amanda said:

It gives you more reason to anticipate a positive reaction rather than a negative one from other people . . . The odds are that for as many people as I've told, there have been more than a few people who know someone directly or in a family that has the same type of disorder. So it makes disclosure easier because it's that much more likely that people will know about it.

Finally, Alex shared that her mother and maternal grandmother both have depression. Her family history helped her come to terms with her own diagnosis since "it showed me that there is going to be a greater level of understanding and a better perspective because it's not the same new idea or new occurrence in our family." The contribution of genetics to her diagnosis encouraged Alex's self-disclosures and helped her explain her condition. She said, "It would help disclosure in a way that I can explain to someone that my family has a history of this and therefore that proves to me that there is a biological component to it that might have been handed down."

*Treatment plan.* Participants reported that participating in a treatment plan (i.e., medication and/or therapy) helped them Come to Terms with their diagnoses and even encouraged their self-disclosures. Felicity described the impact her treatment plan had on her self-disclosure process. She shared:

I'm on medications and I see a psychiatrist on campus once a month and I just made contact with someone at the counseling center so I'm going to be seeing someone on a weekly basis. I've been exercising too, so that's been helping that I see as part of my treatment because it does help. Being on a treatment plan means that I have a closer relationship with someone who is in the



medical field who would know what is going on with me and also, it would be easier for me to disclose what is going on with me and to disclose my mental illness to people if I am on a treatment plan because I feel better and can articulate things better.

Amanda recently began a treatment plan and found it very helpful in understanding and coming to terms with her diagnosis which in turn, encouraged her self-disclosure process. She said:

I went to my doctor and he agreed with the medication for lithium. And I found a counselor who helped me with some cognitive-behavioral kind of techniques and practices that I really enjoyed . . . The treatment plan affects disclosure because as I become more and more comfortable in my ability to control the disorder and my ability to understand the disorder, I think I'll disclose more and more gradually.

Amanda further described how her treatment plan encouraged her self-disclosure:

I think the treatment is a good thing because it's defeating what used to be a battle. It affects disclosure because over time, I'll become more and more willing to disclose it. Before I was on a treatment plan, I couldn't get a handle on anything myself and I felt constantly defeated and so I didn't want to share it with people, it was just a negative part of my life. Now that I'm on a treatment plan, I have goals and I'm reaching them and I can see that I'm accomplishing things. My whole frame of reference with it is positive, so therefore I'm more willing to disclose.

X described his treatment plan as a combination of therapy and medication to manage his depression and talked about how this intervention helped him accept his mood disorder and encouraged his self-disclosure. He expressed:

Going through treatment helped me understand so many things. Before when I didn't have treatment, when I wasn't accepting my own illness, I didn't understand how things related to one another, so I didn't want to disclose because I couldn't articulate these things to anyone else if I didn't understand them myself. Treatment helped me tremendously and now I have a language to use to express myself.

Once participants were diagnosed with a mood disorder, they described individual Reactions to receiving their diagnoses. They also experienced a process of Coming to Terms with their diagnoses which was influenced by factors such as messages they received from family, family history of mental illness, and treatment plan. For Alex and Felicity, Type of Disorder was significant. Coming to Terms was not a linear process occurring immediately after *Receiving Diagnosis*, but an on-going process that participants revisited at different points in their development and degree of acceptance of their mood disorder.

*Receiving Diagnosis* initiated a process of questioning and constructing the meaning of this new identity. Negotiating the meaning of their diagnoses led them to the process of *Constructing an Illness Identity*.

#### *Constructing an Illness Identity*

The process of *Constructing an Illness Identity* is described through its three subcategories: (a) Definition – the participants' perspective or outlook on mental

illness, (b) Orientation – their sense of identity with respect to their mood disorder and (c) Living with the Disorder – their reports of how their mood disorders impacted their lives. The participants engaged in an ongoing process of understanding their diagnoses and making meaning of their new identities as people with mood disorders. The participants described their point of view of mental illness, constructed and negotiated the meaning of their identities as people with mental illness, and expressed how their mood disorders impacted their lives.

### *Definition*

The participants shared views about their disorders which revealed their beliefs about the nature of mental illness. This gave insight into how they perceived their disorders and how they might approach self-disclosure. June spoke of the importance of self-disclosure to help people understand her struggles better and relate to her experiences. She used a metaphor of a person in a fish tank to reference her view of depression when self-disclosing to others. June said:

The way I think about depression is that if you think of a person in a fish tank and the fish tank contains everything in your life – your job, school, friends, family – everything that is connected to them is in this fish tank and ordinarily it is filled with air and water and I feel like for people with depression, it's filled with wet cement. Everything that the person does is through this wet cement that is in the process of hardening. And that represents that everything that you do from the most simple to the most complex is through resistance that most people don't experience.

When she shared materials for document analysis (Appendix I), June further explained that at times, she felt “a desire to kill the diseased part of me, this illness in me, this part of me that I don’t feel good about.”

X described his perspective of living with depression and the nature of mental illness. He shared:

How do I live with my illness? It’s difficult; it’s day by day. Some days are better than others are. Some days I feel that the illness is more of a physical, chemical thing and other times I feel that it’s something I can control via different ways of thinking, things like that . . . I feel like it’s walking in the dark. I don’t know what to expect some days. I just try to deal with things as they come.

When he described materials shared for document analysis (Appendix I), X said:

Sometimes, when I was really depressed and I would think about things so much, I would get trapped by this feeling of anxiety and absurdity that nothing really meant anything, that what are we all doing here? Why am I doing this? Why am I going through the motions? I felt as though I was this artificial human being.

Because of the unpredictable nature of his depression, X was open to self-disclosing his mood disorder in order to “access resources and gain understanding for my plight.”

### *Orientation*

Each participant expressed varying degrees to which his/her mood disorder was integrated into his/her sense of self. Students struggled to negotiate the meaning

of their identities as people with mood disorders. Felicity often wondered, “Is this a part of who I am? Is this a part of my identity?” Since being diagnosed with bipolar disorder Olivia reported less self-confidence and said, “I’m not sure of who I am anymore.” Despite living with his diagnosis of bipolar disorder for nine years, David expressed the following: “I don’t know who I am . . . I can’t characterize myself too well because my life has been so unstable and I haven’t really known who I am. It’s really difficult to identify myself.”

Every student was adamant about not allowing themselves or anyone else to be defined by public notions of mental illness or to view mental illness as their only dimension of identity. They believed that the mood disorder was an integral part of their identities, but clearly expressed that it was only one aspect of their being. The struggle to construct and negotiate the meaning of their identities with respect to their disorders greatly impacted their decisions about self-disclosure and led many participants to avoid disclosure. June explained:

The big worry is that depression is all they’ll see of me. That negates other aspects of my identity. I become depressed girl. I’m not given the same concern to all of the other very basic, very valid aspects of my identity, of who I am. A concern is that the depression will come to define me. I want to be seen as a complex person. I don’t want to be seen in a limiting way. This plays in my mind when I consider disclosure.

Felicity shared June’s concern and offered a similar perspective. She said:

People tend to define who you are by what you disclose. I feel that this is a part of who I am, so I guess I would disclose it to people who are close to me.

But also, I don't want people to totally define me by this . . . I feel I have depression, but I am not depressed girl. I have so many other things that can describe me. So many other traits that are descriptive about who I am and this is just one of them, it's just not all of who I am. People who know me and know my other traits, it's a lot easier for me to say that I have depression because they know that I'm more than that.

Jennifer explained that her reluctance to self-disclose her depression was in part due to her perception that depression would define her. She said, "You would be this person with depression. You wouldn't be this person first." David feared his disclosure of bipolar disorder would "put some sort of barrier between me and that person and I'm afraid that the person would no longer see me as who I am but as a mentally ill person." And X shared, "when I tell someone that I have clinical depression, I no longer become X, I become someone who has depression . . . It completely corrupts your identity and it's all they see - the illness instead of you as an individual." The concern about being defined by mental illness as an outcome of self-disclosure was overwhelmingly shared by the participants. Alex shared her worries: "I'd worry that people would see me as a depressed person and not a person with other characteristics and experiences." X used caution when self-disclosing his depression to others because "people will see the illness before they see me." As a result, he said, "You have to be careful who you disclose your illness to and who you don't."

In contrast, Billy was motivated to self-disclose to show people that bipolar disorder was not a "determining factor" of his identity. He said:

I think it's unrealistic for someone to try and define me by that one thing alone and I don't have too much of a problem showing other people that in most ways I'm just like everyone else. Part of the reason why I want to disclose to people is to show them that this is not all that I am.

### *Living with the Disorder*

The participants described how their mood disorders impacted their lives. They described how they experienced living with their disorder across various situations and shared examples from their academic and social lives. Living with the Disorder affected their grades and ability to persist through college as well as their relationships with others including socializing with peers and establishing relationships. Exploring Living with the Disorder describes the qualitative experience of living with a mental illness on a college campus and raises awareness for their challenges and struggles. Describing the symptoms of a depressive episode, Felicity said, "I start crying a lot. Sometimes I can't eat at all, other times I eat a lot. I curl up in a ball on my bed and won't move for a long time. I keep the lights off, have the door closed, and don't want to talk to anyone. I stay inside, don't go out, stuff like that."

The participants described difficulty persisting through college given their experience living with a mood disorder. Felicity spoke about the academic challenges imposed by her mood disorder. She said:

It interferes with my work at school a lot because I don't know when I'm going to get depressed and I feel that when I get really depressed, I can't get out of bed at all, there is no way. If someone tried to get me out of bed, I'd

curl up on the floor and I wouldn't be able to move. It would take me 10 times longer to do an assignment while I was depressed or I probably wouldn't be able to do it at all. It gets in the way of that because I can't guarantee that at the time I've scheduled to study that I'll be able to do work. And Alex said, "The illness inhibits how well I can perform at everything I'm trying to do. I guess college puts stressors on the illness and the illness inhibits what I can do in college. When I'm depressed, it makes me tired and when you're sleepy, it makes it hard to get things done." For Billy, having bipolar disorder impaired his ability to concentrate and make long term plans. He shared, "Bipolar makes it difficult for me to look into the future and plan ahead for things like long term projects or anything long term. So in some classes it was having an effect on me because I was having trouble making a plan for what I was going to do for a project or anything like that."

Participants described how the concept of "lost time" was a significant way in which their mood disorders impacted their lives, especially influencing their academic aspirations. Jennifer talked about how her depression impacted the direction of her academic and career goals. She said, "If it hadn't been for depression, I don't think I would still be going to college now. I think I would have finished already. I think I would have gone straight from high school to college and probably had some great job by now doing something different." For David, who had been in college for nine years, bipolar disorder posed many obstacles in his ability to finish college. He shared his frustration and struggle to complete coursework:



I've gotten Fs in classes that I was never really able to complete and I was never really functioning well enough to get to school and drop the classes . . . Just given that I've been in college for nine years, bipolar has had a major affect on my academics. I've had to withdraw from classes or drop classes and then take them over again, and then I'd get sick again and have to take them over. There are many classes that I've taken over four or five times and right now I'm working on incompletes in classes that I didn't finish because I was too ill . . . You start things then you get depressed and you can't finish them.

In addition, June described the concept of "lost time" in the following way and wondered how her life would have been different had she not been diagnosed with a mood disorder. She expressed her questions and frustrations:

There are basic things like not graduating in four years, having incompletes and withdraws, stuff like that. There is this frustration with this time where I feel like my energy and enthusiasm are sapped. I think about what I could have done had it not been for mental illness entering my life. For me, part of it is completing academic credits, but it's more about what kind of work could I have done? How could I have developed myself as a writer? How could I have developed relationships with people? How would I have done all this stuff?

The experience of Living with the Disorder made social interaction difficult for the participants. Felicity shared,

People will ask me to go out with them, and I'll just be too tired because I feel tired a lot. Just breaking plans with people a lot. Some of them understand, but I'm sure that some of them feel that I'm not a reliable friend . . . It hasn't gotten in the way that much, but at the same time, I feel bad, it makes me feel sad, upset that I have to cancel on them. I'll tell them that it's because of my depression, but that excuse gets old too.

David described his struggle to maintain connections and build relationships with people. He shared:

You make a lot of friends and then you isolate yourself from them, so you ruin relationships . . . It's been very, very difficult to say the least because there is no stability in my life . . . I think that it's very harmful towards my own development because I want to have a support network and I want to have friends who I can have a good time with and I want in the future to have a relationship or get married, but because of the instability in my life, it's very painful because I feel like if I have a relationship with anybody, whether it's a girlfriend or just a friend, that I'll never really be able to be one person. I'll constantly be either a manic person or a depressed person and it makes it difficult to have relationships with anybody.

Jennifer talked about how her reluctance to disclose her depression has impacted the quality of her friendships, making it difficult for people to really know her. She said, "I don't think my friends are very close to me because they don't know that much about me. I don't think that a lot of people know me very well. I have more

superficial friendships. I get along with people really well, but I don't get really close to them."

The participants also spoke about the invisible nature of mood disorders and how this invisibility impacted their decisions about self-disclosure. Invisibility gave participants greater choice in deciding whether or not to self-disclose their mood disorders. David explained, "Because it's an invisible disorder it becomes totally my choice whether or not I'm going to disclose it whereas if it was some sort of disease or ailment that is visible, you don't have that much of a choice." Amanda spoke of having greater choice and control over her disclosure process. She said, "I get to decide. Nobody can look at me and know that I have a mental disorder. It being invisible means that I have control. It's like protection." For Alex, her mood disorder was invisible because the symptoms were under "control." As such, she expressed a willingness to self-disclose, saying, "Now that it is invisible, I'm more willing to disclose it because I have control over it . . . I'm dealing with it successfully now and it's able to be invisible and I'd rather talk about it when it's like that than when it's nuts and out in the open."

In contrast, Felicity shared that the invisible nature of her mood disorder makes self-disclosure "hard, a hassle, and draining," something that felt more like a "burden" than a choice. She explained:

If you want people to understand what you're going through, then you have to tell them if it's something that is invisible. I feel like it's a burden too when I feel like I can't deal with what is going on in my life and then I have to sit down and write in an email and explain, that is a burden. I also feel like it's

something that I have to deal with also because I can't expect people to know everything about me if it's not on the surface and if someone doesn't know me well, then part of what I have to do is to try to explain what is going on.

X talked about the importance of self-disclosing his mood disorder to gain understanding for his behaviors and to decrease potential misconceptions. He said:

Unlike many other illnesses that are noticeable physically, with mental illness the disclosure is all on you some of the times. You have to disclose it. You have to acknowledge it verbally, otherwise people won't know and people may misinterpret your actions as being different and they may attribute your actions to something else rather than your mental illness, so it's something that you have to clarify that it's your illness.

### *Impact of Stigma*

Interestingly, each participant reported perceptions of mental illness stigma as significantly influencing his or her decisions about self-disclosure, yet none cited an actual incident in which he or she was a victim of stigma. The participants' general awareness of stigma associated with mental illness and the fear of possibly being a victim was enough to caution them when making decisions about when, where, and to whom to self-disclose their mood disorders. Participants mentioned stigmatization as a likely outcome of self-disclosure which led to a loss of self-confidence and heightened reluctance to self-disclose. They often pointed to media sources such as television, movies, and books as contributing to societal stigma. The images of mental illness portrayed in media left them feeling isolated and concerned about how others would react to them as a result of their disclosures and ultimately limited their

disclosure experiences. Participants offered several descriptions of mental illness stigma and reflected on how this stigma impacts their decisions to reveal or conceal their identities as people with mood disorders.

David offered the following description of public conceptions of mental illness informed by media portrayals of mental illness. He said:

People feel that people who are mentally ill are totally out of control and acting really strange or weird all the time and they're outcasts and are a different group, a different society. The healthy people don't want to have much to do with that. I think a lot of people pay attention to the media and that helps inform their opinions of mental illness and what people with mental illness are all about.

David went on to say,

I don't want people to rely on movies or the popular media. I don't want people to think that I'm going to go and kill somebody just because they hear one person who happens to be mentally ill that did. I have some worries that they might get a negative view of people who are mentally ill and a view that they, including myself are different and don't have the same type of thoughts that they have, and the same type of goals and wishes.

Alex reflected on the media's ability to influence societal norms and offered the example of the popular sit-com *Friends*. She shared:

On TV shows like *Friends*, none of them are depressed and seeing a psychiatrist at any point and so it doesn't come up ever. So if it doesn't ever come up in the media which is the place that our society is supposedly

reflected, then why should it come up in real society? As a result of that, there is a caution to disclosure and there is a line that you have to follow and unspoken rules that you have to watch out for.

Amanda blamed the media for providing skewed images of mental illness and admitted that she believed the images and messages portrayed on television until she took a psychology class. She described mental illness stigma as shown in television and movies and depicted in books. Amanda shared:

In movies, mostly and occasionally some books I've read people are portrayed in straight jackets, having to be in padded rooms, not able to hold a job, not able to interact with normal people, talking to themselves, walking around aimlessly, you name it . . . They were portrayed on TV as these people who were crazy, like not ill, but crazy. Until I took a psychology class, I thought that everybody who had any type of disorder couldn't function on an everyday basis, wasn't a normal person. Unfortunately, a lot of people are still that uneducated about the illness and would think that as well. So, the media and all that stuff is where most people get their knowledge and it's very far from the truth.

Olivia commented that stigma is attributed to a fear of mental illness and supported by a general belief that mental illness is a flaw in character. She said, "I think a lot of people are afraid of mental illness. I think people see it as more of a flaw and more of something that you brought on yourself." And X said:

I've heard mental illness being described as a lack of moral character like we are not strong enough; we are not capable of dealing with our problems.

Instead, we just use it as an escape. I've heard us being classified as just being crazy, psychologically defective, belonging in straight jackets in mental hospitals. Stigma is everywhere.

Alex described a general lack of empathy and understanding in society for people with mental illness and a belief that people with these disorders have control over their symptoms and can "get over it" if they choose. She shared:

People think that everyone gets depressed and if you just try hard enough, you'll get over it. If you say "I have cancer" people will say "Oh my God, you can't help that" and you'll get supported. But if you say you have depression, people will say "Just stop thinking about it and get over it, it's not a big deal." That is part of the stigma. That is the reality of how society looks at things . . . With cancer, people see it as something that happened to you and they feel sorry for you and they want to support you. With depression, they don't feel sorry for you because I think people see it as something that you brought on yourself or something that you're just choosing to not get over as hard as you can.

Alex was concerned that knowledge of her mood disorder would overshadow other aspects of her identity and because of stigma, she would not be seen as an individual. She said:

I don't disclose to people who I don't know well because the societal image is placed on me. That is society's image and that is not me. I'm not seen as an individual, I'm seen as a whole grouping of people, a whole grouping of disease that isn't me. It's a blanket image of me.

June also expressed concern that that her diagnosis would “negate other aspects of her identity” and that she would be viewed as “a fixed identity, a fixed label.” In addition, Jennifer revealed that stigma and labeling is much of the reason why she doesn’t disclose her depression. She said, “Many people without mental illness have this view of everyone being the same . . . There is a huge stigma and once you put that on you, it’s not going to go away.” Amanda carefully selects her disclosure recipients and reveals her depression to people who will get to know her beyond the label of depression and mental illness stigma. She reflected on the role of stigma in her decisions about self-disclosure and shared:

Stigma makes me less likely to tell people because I have fully accepted the fact that most people are not going to understand and they’re going to stick to the stigma and never get to know the real me beyond that. That is a lot of the reason. Otherwise, I probably would tell everyone. I have no reason not to if it weren’t for stigma. That is a big chunk of the reason why I have to choose and evaluate who I disclose to.

Amanda went on to say that because of stigma, she is “afraid of what people are going to think of me. Being afraid of how people will react is like 90% of the reason why I wouldn’t tell someone.” Alex shared similar concerns about others’ perceptions of her and was careful in making decisions about when and to whom to disclose her mood disorder. She said:

Because there is negative stigma attached to it, it does shadow whom I disclose to because I wonder if that stigma will enter our relationships. Will I remain Alex or will I become Alex the depressed person? This is just a part of



me. I'm still Alex. That affects who I disclose to. If I think they will remain unbiased and remain objective about the stigma, then I can disclose to them, but if I think that they will pity me, then I'm not going to disclose to them.

Given the stigma of mental illness, participants expressed concern about how people would react to their disclosures. Others' perceptions greatly impacted their decisions about self-disclosure and led some participants to avoid disclosure. This was true for Felicity who said, "if someone will look at me and think I'm crazy because of it, then I won't tell them." Amanda was adamant about not being treated differently as a result of having depression and often decided not to self-disclose this aspect of her identity. She said:

People would treat me like a psychiatric patient, like a nut case, like someone who needed supervision and couldn't be treated on a normal level. I don't want to be treated like a child or someone who needs supervision. I don't want people to treat me any differently than they treat anybody else. That would keep me from disclosing.

Participants overwhelmingly cited stigma as a deterrent to self-disclosure. Students expressed a desire to "not be treated differently" (Jennifer) and experienced an internal struggle to balance decisions to reveal or conceal their illnesses. As Jennifer simply put, "Stigma prevents me from saying anything." For Felicity, "Stigma is the biggest influence on me disclosing anything. It's based on what people have in their mind about what a depressed person is and that is a huge factor for me." June described the pressure that stigma creates for her when making decisions about self-disclosure. She said, "People see depression as something that

you should be able to overcome. This impacts the shame aspect like feeling like I should just be able to function and thrive in spite of the illness. It inhibits disclosure greatly.” In addition to inhibiting self-disclosure, stigma led to feelings of decreased self-worth for June. She shared:

Stigma inhibits disclosure. It impacts more the way I see myself and the stigma of mental illness is a bigger deal to me in terms of seeing myself as a less worthwhile person, seeing myself as a flawed person, and I guess that self-perception feeds into self-disclosure.

Perceptions of stigma created uncertainty among participants when making decisions regarding how, when, and to whom to self-disclose. Concerns about being viewed as a label instead of as an individual who has many dimensions of identity led the participants to largely conceal their mood disorders. The potential negative consequences resulting from their disclosures heavily weighed on participants as they made decisions about how to balance decisions to reveal or conceal their mood disorders. Olivia shared, “Stigma is the only consequence that could possibly occur if I disclose to someone – it’s that fear that they’re going to take up that stigma and think I’m crazy and out of my mind. That is the only deterrent in disclosing to someone.”

### *Perceived Campus Support*

Stigma continued to impact participants’ decisions about self-disclosing their mood disorders by influencing their perceptions of the support they felt or didn’t feel on campus and the effect this support or lack of support had on their decisions about self-disclosure. Participants shared stories involving faculty, staff, mental health

service providers, and peers both with and without mood disorders. Their perceptions of campus support from these sources shaped their experiences related to self-disclosure and either encouraged or discouraged them from revealing their identities as students with mood disorders. Students who perceived a high degree of support were more willing to self-disclose. Students who did not experience a high degree of support largely felt disconnected from campus and tended to conceal their mood disorders.

June perceived a high level of support on campus and had experience self-disclosing to faculty, staff, mental health providers, and peers. She shared:

Having positive experiences makes it so it's not such a big deal to self-disclose . . . The support has encouraged self-disclosure. The biggest reason not to self-disclose is that you won't be supported and since from my experiences, that fear isn't there, it's not such a big deal for me.

Alex did not perceive a high degree of support from campus sources and had more limited disclosure experiences. The campus size made it difficult for her to navigate the campus and to find people whom she trusted with her disclosures. She said:

The size of this campus makes it hard to get to know people and trust them and the personal relationships are lacking which keeps me from disclosing . . . It's so huge so there aren't a lot of opportunities for close relationships that allow for self-disclosure. I don't see this campus as a catalyst to finding an avenue to self-disclosure.

Felicity also shared that the size of campus made it difficult for her to find supportive resources and contributed to her feeling “lost and alone.” She shared:

I feel like this school is really big and when you need help with anything, it’s hard to find anything, especially when you’re going through a period of really extreme depression or whatever. When I feel that way, it’s hard for me to go out and find those resources and I don’t feel like they’re easy to find either. I don’t really feel like there is that much available help.

Olivia was challenged to make connections with people on campus and didn’t perceive a high degree of support which made it difficult to self-disclose bipolar disorder. She offered the following perspective about the campus: “This is not a very personable campus . . . People seem to always be in a hurry and are kind of doing their own things. It makes it more difficult to disclose because people don’t seem as willing to take the time to listen.” Billy didn’t perceive a high degree of support on campus and shared that he doesn’t feel connected to campus life. He said, “I walk around to some degree feeling that I’m not part of what is going on and I make a clear distinction between the rest of the world walking around and me. I don’t feel integrated completely.”

### *Faculty*

Five of the nine participants (David, Felicity, June, Olivia, and X) had experience disclosing their mood disorders to faculty members and shared overwhelmingly positive experiences which encouraged future disclosures to other faculty. However, David revealed a negative incident with a professor that impaired his confidence to self-disclose to other faculty.

Felicity disclosed her mood disorder to an English professor and was pleased to receive a follow-up email from the faculty member with suggestions for how to balance her schedule and manage her time more efficiently. X talked about previous disclosure experiences in which faculty were “very knowledgeable and very caring, giving me the extended time that I need.” Olivia had a positive disclosure experience with an instructor that served as “encouragement for me to disclose to other professors.” June described how faculty have supported her and in turn, encouraged her future disclosure experiences. She shared:

The biggest thing is understanding that deadlines and timelines and stuff like that are not absolutes, that they’re negotiable, flexible, that people are different, that they are human. They have these complex lives. Faculty have been understanding and have supported me.

Felicity and Jennifer reported a perceived difference in the amount of support provided by faculty from different academic disciplines. The degree of support they perceived from their academic departments encouraged their decisions to reveal their mood disorders. Felicity shared:

It’s easier to talk to faculty in the psychology department and now that I’m in sociology, them too because they are more understanding because that is what they are studying. I don’t know how I would feel about a biology professor or someone in music.

Jennifer, a psychology major, shared that her academic department served as a significant source of support. Although she had not self-disclosed to anyone on

campus, her perception of a supportive department was encouraging her to eventually self-disclose her depression. She said:

I think that especially in the psychology department, if you told someone, I really believe that they would be so nice about it. There is support there. That is encouraging me to disclose . . . Being around people in psychology makes me feel better about depression because everyone understands and people don't go into psychology because they want to make fun of people with mental illness. People go into psychology because they want to learn about it and maybe they have an illness too.

David experienced a negative incident with a faculty member when negotiating an academic accommodation approved by the Office of Disability Support Services (DSS). That experience led him to be more cautious about future disclosures. David said, "I'm very careful and in the future, I'll continue to be very careful. In fact I try hard now not to get in a position where I have to or need to or want to disclose to faculty." David also shared having tremendous feelings of guilt and shame when self-disclosing to faculty and requesting academic accommodations. He shared:

It's just that I've asked in so many classes for concessions for extra time so often that I feel so incredibly ashamed. Even though they're generally very helpful, I feel like I'm bothering the professors, I feel like they don't have time for this . . . I come out in the end feeling guilty and feeling ashamed and feeling like I've taken advantage of them. It's gotten to the point where I've taken Fs on things rather than ask for more help.

The four participants (Alex, Amanda, Billy, and Jennifer) who had not self-disclosed their mood disorders to any faculty members shared that their reluctance was largely due to perceptions that relationships with faculty are “not that personal” (Alex) and that faculty are “at a different level” (Jennifer) and they “don’t feel comfortable at all talking to a professor” (Amanda). And Billy said, “Professors don’t have any education on dealing with people with any disabilities, especially bipolar disorder. It makes it a more difficult task, more uncomfortable to disclose.” These participants generally perceived a low degree of support from faculty which kept them from self-disclosing. Alex shared:

Because I’ve only known teachers for a semester at a time, there isn’t the time period to gain a greater mutual understanding that would allow me to bring it up. Because of the low contact, it just doesn’t happen that much. Disclosure doesn’t happen because I don’t feel comfortable.

For Amanda, “it’s never an option to just go and talk to the professor.” She went on to say:

I usually don’t speak to my professors at all. I don’t work well with authority. I’m fearful of it. I’m shy when it comes to people who are in a higher place than I am and I wouldn’t feel comfortable talking to them about a lot of things.

Jennifer offered the following description of a student-faculty relationship:

There is a power differential there – they have power over you. Big power if you’re concerned about your grade which I am . . . A professor’s job is to educate you. They don’t need to be up close and personal with you to educate

you. They are not there to be your friend . . . I don't really have a close relationship with any of my professors.

Students shared the importance of being viewed as competent and did not want faculty to perceive their disclosures as excuses or requests for special treatment. Their beliefs that faculty would perceive them as less capable was fueled by the stigma of mental illness and inhibited their self-disclosures to faculty members.

Jennifer said:

I guess I feel a little removed from faculty. Those dynamics play a huge role. With faculty, you want to put your best face forward with them. I don't want them to think that I'm flaky and unreliable . . . I don't want them to think that I'm hoping for a break. I don't want to be seen as someone who is trying to use it to get an easier time. I do want to establish myself as being competent, functioning, attending to everything that I need to.

Despite his positive experiences disclosing to faculty, X shared that mental illness stigma influenced his views of how faculty would receive him after disclosing his depression. He shared, "Getting the help you need without people thinking that you're using it as a cop-out, to get a free ride. That is the most difficult thing to navigate when you're self-disclosing at a university setting."

Being viewed as competent was a significant factor influencing students' decisions to balance the need to disclose their mood disorders to benefit from academic accommodations with their fear of mental illness stigma – of being viewed as different and incapable of handling a college load. This fear greatly inhibited students' self-disclosures and limited their opportunities to receive accommodations.



Establishing herself as a competent student was important for Olivia who said, “I don’t want people to make an exception for me because I’m capable of doing what others can do . . . If I did tell some of my professors, they might think that I’m just telling them to make an excuse for maybe why I didn’t get something done.”

Amanda did not disclose to faculty for fear that they would dismiss her abilities and tell her she didn’t belong in college. She said, “I would never think to tell a faculty member because I feel like it would make me look like I’m not capable of being here . . . I don’t want to give them a chance to tell me I don’t belong here.” Billy said he felt “awkward and uncomfortable” disclosing to faculty “because I still feel it’s wrong to use that as an explanation for why I wasn’t going to complete things on time.” In addition, Alex shared that she doesn’t disclose to instructors because disclosure “leads to them thinking that I want that excuse or that cop-out and that is negative because I’m seen as someone who can’t get her work done.”

### *Staff*

Participants were challenged to recall disclosure experiences with staff members (described as anyone in a non-faculty role, including program directors, academic advisors, resident assistants, and so forth) and generally did not perceive a high degree of support from these professionals. June said:

It tells you that staff is irrelevant. I don’t interact with them or it’s very simple interaction. Why would I? Who would I disclose to? . . . My time on campus is academic time and I either spend time in class or at the library or I’m spending it with professors talking about stuff.

In addition, Olivia said:

I wouldn't disclose to staff because they wouldn't really relate so much, they don't really affect me too much in terms of going to class. Professors have more control over my grades in college in general rather than staff members. So, I don't think that I would have to tell them anything.

Billy shared a negative experience with a Resident Assistant (RA) that led him to perceive staff members as unsupportive. Billy described a disclosure experience to his RA which left him feeling uncertain about his ability to describe and explain bipolar disorder. He shared:

When I lived in the dorm, my RA misunderstood what I was saying and thought I was more of a psychotic, what people think of when they think of people in a mental hospital, and what they've seen in movies . . . She became distant and less willing to help me. She just didn't understand what I meant when I said bipolar illness and I tried to explain it in a way that this person could understand and I thought she did understand, but she didn't.

In contrast, David and X did share positive experiences with staff members who provided support and encouraged their self-disclosures. They shared stories reflecting the support they received from administrative staff after self-disclosing their mood disorders. X received an academic dismissal notice and described the appeals process and how he received support from a dean in the College of Behavioral and Social Sciences (BSOS). He talked about how this support encouraged future disclosures. X shared:

I was in a depression, suicidal, and I was academically dismissed from school because my grades were just horrible. I had to talk to the deans of certain

college programs . . . It was a very empowering experience because he [BSOS dean] congratulated me for coming to him and being able to do all of this despite still being ill . . . It seems as though after I got academically dismissed, I was more willing to disclose, which I thought would be vice versa, but it's not. His support just gives me the will to succeed. So the disclosure not only has become easier but in a lot of ways has become mandatory.

An administrative staff member in the business school served as a source of support for David, identifying resources and helping him work through various issues. David described her as "warm and kind." He said:

She always listens and she is always willing to take time and even if she is really busy, she is willing to set things aside and take time to listen to you. She came across as somebody who is caring and that is basically why I disclosed to her . . . I have had somebody who's been by my side and who has helped me with my education.

### *Mental Health Services*

Participants perceived different levels of support from campus mental health services including the mental health center, counseling center, and disability support services. Some participants were not aware of programs offered on campus and others reported knowledge of existing programs, but felt they were not well advertised. Billy said:

I'm not too aware of what programs are out there for this kind of thing at this university. You probably have to really dig to find out . . . Maybe there are a

lot of things out there but I don't partake in any of the campus programs like that, so I don't really know.

Alex spoke about a general lack of awareness of campus resources. She said, "Counseling services are not well advertised. There are not a lot of groups, lectures, discussions on depression in college and there is not a lot of awareness of campus resources." Felicity expressed a desire to understand the different purposes of the counseling center and mental health center. She shared:

I just wish it was easier, that there was some kind of brochure that would say that this is what you do when you have this and explain the differences between the mental health center and the counseling center and what is better to go to for what . . . When I am going through an episode, when I need the most help, that is when I can't go out and search for the information.

Participants were frustrated with the process involved to make an appointment at the counseling and mental health centers. They complained of long waiting lists and bureaucracy that hindered their ability to securing an appointment with a staff psychologist or psychiatrist and receiving support for their mood disorders. June lamented:

The people who have been the least helpful to me are the people at the counseling center or at the mental health portion of the health center. They have been the absolute worst! All the bureaucratic things you have to go through to get an appointment.

Felicity spoke of the importance of securing an appointment when she exhibited symptoms of her mood disorder as opposed to when symptoms subsided. She said:

There are times when I need an emergency appointment because that day or that week I feel really, really bad. I feel like if I could get an appointment when I need it, I would tell everything that was going on, every feeling that I had, because I would be desperate for help and desperate to feel better. If I had to be on a waiting list, by the time I get there, I might be feeling fine, I might have forgotten some of the feelings that were going on at that time, it's harder for me to express them.

X emphasized the importance of taking initiative to secure an appointment. He said:

The wait list at the counseling center is really long for students who need to get counseling for mental illness or related disabilities. A university of this magnitude, it's so easy to get lost in the cracks. And you have to really keep on top of the disability support services and the counseling center because if you don't, you'll just be forgotten.

Participants were also frustrated with the short-term services provided by campus mental health services and the limited number of sessions allotted per student. Felicity shared:

It does bother me that there are only a few sessions at the counseling center and that when I call the mental health center here, a lot of times they don't have someone available for me to see. I just keep switching around from one person to another and it's hard to get to know them . . . I would disclose more to someone that I connected with and that I had seen for a significant time.

Despite the waiting lists and bureaucracy involved in making appointments with mental health service providers, participants did report that campus mental health services provided a source of support and encouragement. In particular, participants felt support from disability support services, a service provided through the counseling center. Although not all participants were aware that they could qualify for academic accommodations through disability support services, those who did take advantage of this service felt supported and encouraged to reveal their mood disorders to faculty and others on campus in order to secure accommodations. X said, “To get the help I needed on campus, I had to go to the disability support services in order to get the special services, like I needed time and a half on tests and sometimes I have to be in rooms by myself because I’m easily distracted.” And David said, “Since I’m registered with DSS, I get time and a half to take exams and I get a private room . . . Without DSS, I wouldn’t be able to continue on through school.”

Felicity reported that she recently learned through the counseling center that she potentially could qualify for academic accommodations. She was pleased to know of this service and shared the following:

A lot of people think that going out and seeking help is a sign of weakness, but I don’t feel like it is. I feel like whatever I can do to get myself through college because I know it’s not my fault and I do try very hard in school. So, if I can have something that will help me be on the same level as other people who don’t have any problems, then I don’t feel like there is anything wrong with that.

Felicity also felt support from a staff psychologist at the counseling center whose positive influence encouraged her disclosure to a staff psychiatrist at the mental health center. Felicity shared:

When I went to the counseling center and shared what my problems were, the people were not judgmental. So, I was then more willing to go to the mental health center and disclose because I knew that they work with each other and I wouldn't be treated badly.

Amanda mentioned the HelpLine, a campus crisis hotline operated by students as a source of campus support. She described this service as providing a high degree of support to students and felt encouraged to disclose her mood disorder during a time of need. She said:

I think that the HelpLine, well, I've never used it, but I assume that it would be extremely helpful because that is something that I would be able to use in the privacy of my dorm and I know a lot of times last year when I had to deal with being in an episode or whatever you want to call it, I wasn't in the shape to put on clothes and go out and go somewhere. So the fact that I can just call, I can see how that is going to be a huge help if I ever need it. I think that's a wonderful service to have and I'm actually considering volunteering for it.

David expressed a general feeling of support and encouragement that he received from campus mental health services and shared the significance of these services in his ability to persist through college. He shared:

What is significant about this campus is that it has a lot of services available. It has provided services to me that have helped me make my way through

college . . . That the campus has provided mental health care through psychologists, psychiatrists, support groups like in the health center, disability support services, there has been a framework that has been set up and services provided that allow somebody, even somebody as ill as I've been at times to still make their way through school and get a pretty good education.

Another source of campus support was a weekly support group for students with bipolar disorder sponsored by the mental health center. Olivia and David both participated in the group and felt a tremendous amount of support from this experience, providing them a sense of community and encouraging their process of self-disclosure. David described the support group as a "safe place" where he felt understood. He said:

I talk pretty openly and I don't think that I've held anything back. I think having the doors closed – I feel it is a safe place. Everybody can relate, or even if they can't relate, they can try and understand my experiences better than someone who has not had those experiences.

David utilized the support group as a "testing ground" that helped him to prepare for disclosure experiences with people outside the group. He shared:

Sometimes it's a testing ground. Sometimes I'll say things there that I haven't said to anyone. Because it's a testing ground it allows me to feel more comfortable disclosing with other people because I've already gotten a feel for what it will feel like when I say something. So, there isn't as much fear or anxiety inside when I have to disclose it a second time to somebody else outside the group.



The support group experience was significant for Olivia because it provided a sense of community with peers who shared her diagnosis and who could relate to her experiences. This sense of support facilitated her self-disclosure process and encouraged her to feel more comfortable with self-disclosure in general. Olivia shared:

Since everyone in the group has bipolar, I feel much more comfortable saying what my symptoms are or what my experiences have been because every time I said what my experiences have been, someone else will say “I know exactly what you’re talking about.”

She went on to say,

In the support group, we talk about how and if we tell other people. I think that as time goes on, people are telling more people about their bipolar . . . Because I’m going through the group and becoming more comfortable with bipolar I think I’ll become more comfortable even telling other people that I have bipolar.

Olivia shared that the topic of self-disclosure is often raised during group sessions. She reported that the discussions were helpful and provided useful strategies. She said:

In group, we’ll talk about disclosure directly and we’ll discuss how maybe it alleviates depression or how it makes us feel more relieved once we do disclose to someone. We can talk about it directly, I think we encourage each other to find solutions and find ways to disclose without laying all our

emotions on someone. We've also talked about disclosing to professors and how that has gone in individual cases. So I think that it's an encouragement.

### *Peers*

Participants stressed the importance of peers, those with and without mood disorders as a significant source of support. They described the importance of having friends and building connections with other students on campus and how these relationships shaped their self-disclosure experiences. The participants' need for inclusion and acceptance impacted the extent to which they revealed their identities as people living with mood disorders. Amanda described how the support she received from her friends encouraged her to reveal her depression to others. She said:

Getting to know people, having friends, and starting to have a close-knit group of friends made a huge difference. Friends are extremely supportive. They sit and listen which has been crucial. They've never betrayed my trust, never judged

me . . . It's made me more open about it. I became more and more likely to tell people. I put more faith in people and I have more faith in people now.

Felicity spoke about the support she received from her friends and their commitment to helping her seek support when she has experienced depressive episodes. She shared:

Close friends have supported me a lot. When they see me really upset, they ask if I've taken my medication. Also, freshman year when I got really depressed, one of my friends dragged me to the counseling center and went in with me and everything. That helped a lot.

Peers have shown their support in many ways including “just being there” (X) and “listening to me, empathizing with me” (June).

Participants overwhelmingly cited peers with mood disorders and other mental illnesses as a significant source of support during college. They described having a “bond” (X) with students who shared similar diagnoses and how this shared understanding encouraged them to feel more comfortable about self-disclosure.

Olivia said:

It makes it so much easier to tell someone else who has bipolar. That person shares the same insecurities you have about telling other people, but you know that they have bipolar also, so you don’t have any inhibitions when you’re telling someone else who has bipolar because they’ll understand exactly what you’re going through.

X described a sense of understanding and non-judgment among peers with mental illness. He shared:

There is a bond, a kindred spirit kind of thing that we’re both going through similar things . . . We can bounce things off of one another and be there for one another the way no one else could. I think it makes things easier to disclose and you feel that there will be no judgment. When you talk to someone who does have a mental illness, they understand that, so it’s a lot easier to just be yourself and you don’t have to feel like you have to mask your feelings. There is just that understanding.

June also described the shared understanding with peers diagnosed with mental illness. She said, “There are things that are comprehensible to those people that

maybe aren't comprehensible in the same way to people who haven't dealt with mental illness." David described these peer relationships as "compassionate and understanding." And Billy sensed that if peers "have personal experience, they'll be even more sensitive to my feelings." Felicity felt the support was "all about empathy" and "being able to share and relate." She went on to say,

I'm so much more comfortable disclosing to people who have the same type of mental illness or have some kind of mental illness because I know that a lot of them have experienced the same things as me and that they won't be judgmental . . . If I know that the person has some kind of mental illness, then that is a lot easier for me to express.

#### *Attributes of Personality*

It is important to acknowledge each participant's individuality and to recognize that despite sharing the same diagnoses, every student experienced his or her mood disorder uniquely. As such, self-disclosure was unique to each individual and was shaped by his/her personal characteristics or personality. *Attributes of Personality* describe personal characteristics that helped to shape each participant's experiences and reactions related to self-disclosing his/her mood disorder.

#### *Alex*

Alex described herself as "self-reliant" and "independent." She selectively disclosed her mood disorder on a "need to know basis." She explained, "I'm very independent, so in most cases, I don't feel that I have to tell every person what is going on. I do care about the people close to me and it's only fair to let them know

what is going on and not to offer it as a cop-out, but more as a base explanation and to let people know that I'm working on things."

*Amanda*

Amanda often cited "trust" as a prerequisite for self-disclosure. She remarked that gaining someone's trust "takes a lot of time. I'm not the type of person who gets close to people right away . . . I'm not very trusting initially. And I think if I were, I would be more inclined to tell people earlier and to tell more people about my depression, but I'm just not. It takes a lot for me to trust someone."

*Billy*

Billy described himself as an "easygoing person" who doesn't "sweat the small stuff." He shared, "I look at things on a bigger picture – that it's a disorder and in the end it's not the only part of my personality." Billy explained, "I've managed to keep a pretty normal façade. I've been able to take part in the things that everybody thinks is normal for my age group. For instance, I'm here at school. I have romantic relationships and stuff like that." With respect to his decisions about self-disclosing bipolar disorder, Billy said, "If I need to, I will. If it will help me in some way or help someone else understand it better, I'm open to disclosing."

*David*

David struggled with socialization and establishing relationships with others. He explained, "I've always been aloof and really kept to myself and I haven't been open with anybody. I isolate myself and ruin relationships. I have a low self-esteem because of all the pain that I've caused others and that I've had."

### *Felicity*

Felicity described herself as “a very open person” who enjoyed getting to know people and allowing them to know her better. She shared that “sometimes I’ll say too much about myself and that is sort of bad, but I’m just very open and honest and that is why it’s not hard for me to disclose.” For Felicity, self-disclosure was an “easy” process since she is accustomed to expressing her feelings with people. She shared:

I need to talk about my problems, or just what is going on in my life. It connects to disclosure because it’s very easy for me to talk about my feelings to people. So if I need to disclose my illness to someone or I feel it would help me to do that, it’s not really hard for me to talk about my own feelings. I can voice what I feel.

### *Jennifer*

In contrast to Felicity’s approach to disclosure, Jennifer was “really private” and “doesn’t like talking about personal issues a lot” which limited her disclosure experiences. Her concern about others’ perceptions of her also influenced her decisions about self-disclosure. She said:

I just don’t tell personal things about myself a lot. I don’t tell people all that much stuff about myself . . . I want to have it together and I want people to see me as that person. I think that has a huge impact on whether or not I disclose because depression is something I perceive that could be seen as negative that could impact how I’m seen . . . I just don’t want anyone to be able figure out anything about me before they get to know me.

Jennifer also shared the importance of managing how others perceive her. She said:

I am such a private person. I want to have it together and I want people to see me as that person. I want people to see me as someone who is smart, someone who has planned her life out and is achieving her goals. That is the person who I want to be and that is the person I want to present. I think that has a huge impact on whether or not I disclose.

#### *June*

June was open about revealing information about herself as a person living with a mood disorder and described self-disclosure as a “liberating” experience. She remarked that “I’m not into being fake. I’m not into putting all this effort into putting on this mask that conceals who I really am. I hate doing that and I’m not good at that.”

#### *Olivia*

Olivia was diagnosed with bipolar disorder just three months before she became involved in this study and was still coming to terms with the diagnosis and what it meant in her life. She shared, “Before I was diagnosed, I was much more open in general about everything . . . I’ve closed myself off since being diagnosed. I’ve noticed less self confidence . . . I’m not as open as I once was and so it’s more difficult for me to tell someone that I have bipolar because I’m more closed off.”

#### *X*

For X, aspects of his identity, especially with respect to being African American and gay, were central to his experiences and framed his narratives. Of the nine participants, he was the only one who named other social identities (i.e., race and

sexual orientation) as salient to his experiences living with depression. X's narratives often made references to the intersections of his multiple identities which added depth to his stories and enhanced his understanding of self with respect to living with depression. He shared:

My mental illness links to me being male, being African American, being gay.

All these things have all played a role in the mental illness and I feel as though it's given me a peculiar vantage point to exist in a society because I feel as though it gives me a sensitivity to recognize the strife that other people go through. It's made me be able to help me understand what other people are going through and help me better articulate my own struggles with my identity and mental illness. It's just made an impact. It's made me be able to feel people's emotions without them even having to say a word. It's just a way that someone might walk into a room. The way they speak to me, the way they look at me, the way they move, everything, the tone of their voice.

Everything conveys information to me and having a mental illness, having to really struggle with emotions has given me a lens to understand other people's emotions in targeted groups.

X was driven to educate others about mental illness. His reality as a Black, gay male with depression gave him "wisdom" and "compassion" about subordinate group experiences and compelled him to self-disclose his depression to increase understanding of, and awareness for, people living with mental illness and their experiences. He said:



I'm the kind of person who likes to dialogue with people and talk with people in an intellectual way and who likes to help people understand different points of view. I'm good at seeing things from a variety of perspectives and it makes me want to help people understand what different types of people are going through and I think that when you have a mental illness or you're part of a subordinate group in some way, it gives you wisdom, the fact that you can see things that other people may not and helping other people to be more aware of things they took for granted or that they didn't see makes me feel good about disclosing my illness and other aspects of my identity.

### Chapter Summary

Undergraduate students described the factors and influences that encouraged and inhibited their self-disclosure of a mood disorder while in college and how they made decisions to reveal or conceal this dimension of identity. The central or core category that described self-disclosure was *Lifting the Veil*. The five key categories that related to the core category as causal or intervening conditions and contributed to the development of the emergent theory were *Receiving Diagnosis*, *Constructing an Illness Identity*, *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*. Chapter V offers implications for practice and further research and describes the relationship of the emergent theory to the research questions and to existing literature.

## CHAPTER V

### DISCUSSION

Chapter V explores the connections among the emergent theory and the initial research questions, as well as to the literature reviewed in Chapter II. Additionally, strengths and limitations of the study are presented, as are implications and recommendations for practice and future research. An overview of the findings is presented first.

#### Overview of the Findings

The emergent theory *Lifting the Veil on Invisible Identities: A Grounded Theory of Self-Disclosure for College Students with Mood Disorders* described how the nine participants in this study make decisions about self-disclosing a mood disorder while in college. Through the key categories of *Receiving Diagnosis*, *Constructing an Illness Identity*, *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*, the specific factors that influenced this process emerged.

The core category *Lifting the Veil*, representing the main theme of the students' narratives of self-disclosure, described self-disclosure and revealed factors and influences that encouraged or inhibited students' decisions to reveal or conceal a mood disorder. This core category described the *Self Disclosure Decision Making Process* that participants' experienced as they chose when, how, and to whom to disclose their mood disorder as well as the act of *Self Disclosure* itself. The *Self-Disclosure Decision Making Process* described students' Motivation for self-disclosing or *Lifting the Veil*, and the Conditions which encouraged or inhibited their self-disclosure. Participants were motivated to self-disclose a mood disorder to: (a)

explain behavior; (b) receive support and academic accommodations; (c) build and enhance relationships; and (d) educate and raise awareness for mental illness. The various conditions necessary to facilitate their self-disclosure included: (a) establishing rapport with the recipient of their disclosure; (b) having a degree of control over symptoms and who had knowledge of their identity as a person with a mood disorder; (c) experiencing mutual disclosure; and (d) managing how others perceived them.

The act of *Self-Disclosure* was described through its five subcategories: Context (setting or situation), Approach (aspects of a personal style, or approach), Method (in person or via email), Characteristics of Disclosure Recipient, and Outcome of disclosure experiences. The participants described particular settings and situations in which self-disclosure occurred. They preferred to self-disclose their mood disorders in private settings often with the door closed and shared that self-disclosure typically was a one on one experience with another individual. The participants also described aspects of a personal style or approach to self-disclosure. Some preferred to ease into it very casually and others used a more direct approach. Additionally, participants identified two ways in which they self-disclosed. Some chose to reveal their mood disorder in person and others preferred to do it via electronic mail. When deciding to whom to self-disclose a mood disorder, participants looked for particular characteristics. They described recipients of their disclosures as “trustworthy, nonjudgmental, caring, supportive, understanding, and tolerant.” Participants also described outcomes of self-disclosure which included experiencing a sense of relief after self-disclosing a mood disorder, feeling connected

with others, and enhancing their relationships. Outcomes of non-disclosure or concealment of their identities as people with mood disorders were negative. Participants carried heavy burdens to keep this part of their lives hidden, which increased their feelings of isolation and alienation.

The five key categories that emerged from the data represented specific factors that influenced the participants' decisions about self-disclosure. The key categories and the core category collectively formed the emergent theory that explained and described self-disclosure for undergraduate college students with mood disorders. *Receiving a Diagnosis* of bipolar disorder or major depression initiated the self-disclosure process for each participant. Participants described a range of individual experiences and responses to their diagnoses. Many felt relieved and validated and thus were encouraged to self-disclose. Some experienced disbelief or denial about their diagnoses, which led them to conceal their identities as people living with mood disorders. For some participants, Type of Disorder was significant. Three participants who were initially diagnosed with major depression later identified as having bipolar disorder after receiving a new diagnosis from their psychiatrists. Two of them described how self-disclosure was different for each mood disorder and shared that it was particularly challenging to reveal bipolar disorder which they perceived to carry a more severe stigma than depression. Coming to Terms with a diagnosis was developed and influenced through the reactions of family to diagnoses, the participants' enhanced personal understanding and awareness of their diagnoses, family history of mental illness, and participation in a treatment plan.

*Receiving a Diagnosis* led participants to the process of *Constructing an Illness Identity* in which they described their outlook on mental illness, constructed and negotiated the meaning of their identities as people with mental illness, and expressed how their mood disorders impacted their lives. The remaining factors or key categories contributing to the development of the core category, *Lifting the Veil*, and increasing understanding of how students make decisions about self-disclosure are *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*. The participants overwhelmingly cited stigma as a deterrent to self-disclosure. Their general awareness of stigma associated with mental illness and the fear of possibly being a victim cautioned them when making decisions about when, where, and to whom to self-disclose their mood disorders. The participants also expressed a desire to not be treated differently and experienced an internal struggle to balance decisions to reveal or conceal their illnesses. Their perceptions of campus support shaped their experiences related to self-disclosure and either encouraged or discouraged them to reveal their identities as students with mood disorders. Students who perceived a high degree of support were more willing to self-disclose. Students who did not experience a high degree of support largely felt disconnected from campus and tended to conceal their mood disorders. Self-disclosure was unique to each individual and was shaped by his/her personal characteristics or personality. *Attributes of Personality* described personal characteristics that helped to shape each participant's experiences and reactions related to self-disclosing his or her mood disorder.

Through an exploration of literature and existing research, the factors contributing to the participants' decisions about self-disclosure are further

understood. The following section reviews the emergent theory in relation to the research questions and to literature which was introduced in Chapter II. In addition, I reviewed some new research to provide added comparison points and discover a deeper understanding of the grounded theory.

#### Discussion of Emergent Theory in Relation to Research Questions and Literature

The review of literature and existing research presented in Chapter II provided ways of approaching and interpreting data and helped to focus the study by stimulating questions and providing comparison points with which to explore and understand the experiences of the participants. I used existing theories or frameworks as points of reference for the narratives and experiences which emerged from this study without constraining the generation of the emerging theory.

This chapter connects the findings of this study to the initial research questions and compares the findings with research presented in Chapter II to facilitate understanding of the experience of self-disclosure for college students with mood disorders. The emerging theory *Lifting the Veil on Invisible Identities* presents new ways to consider previous research and offers implications for continued research on self-disclosure. Two research questions guided the process of exploring and understanding how students make decisions about self-disclosing a mood disorder and the factors and influences that contribute to their decisions. These were:

1. How and when do college students with mood disorders decide whether or not to self disclose their identities as people with mental illnesses?
2. What influences and factors have contributed to students' decisions about self-disclosing a mood disorder while in college?

*How and when do college students with mood disorders decide whether or not to self-disclose their identities as people with mental illnesses?*

Lynch and Gussel's (1996) research on college students with psychiatric disabilities indicated that self-disclosure is a complex process entailing multiple dilemmas for students including when to disclose, how to disclose, how much to disclose, and to whom to disclose. The findings of this current study *Lifting the Veil on Invisible Identities* revealed that the participants endured similar dilemmas and demonstrated that self-disclosure was not a linear, sequential process, nor was it experienced in the same manner for each participant or in all situations. Rather, self-disclosure is a complex phenomenon that is very personal and individual to each student and informed by multiple factors and situations. How and when students decided whether or not to self-disclose their identities as people with mood disorders was a function of the intersections among many variables including the degree to which participants felt comfortable with their diagnoses (a process described as coming to terms, influenced by family response, increased self awareness and understanding, family history of mental illness, and treatment plan), their perceptions of stigma and campus support, characteristics of the discloser and recipient, status of the relationship between discloser and recipient, and aspects of the setting and situation. This is consistent with research (Goodstein & Reinecker, 1974; Jourard, 1971; Petronio, 2000) which described similar variables that influenced an individual's decision to self-disclose personal information about oneself— namely, the characteristics of the discloser and recipient, status of the relationship between them, as well as aspects of the setting and situation.

The participants shared their motivation for self-disclosing a mood disorder which included needing to explain behavior, receiving support and academic accommodations, building and enhancing relationships, and educating and raising awareness for mental illness. Three of these motivators (i.e., explain behavior, enhance relationships, and educate others) focused on the participants' desire to be understood with respect to having a mood disorder. Through their self-disclosures, participants believed that by being open about this dimension of their identities, they could strengthen relationships and achieve intimacy by allowing others to better know them. However, they were greatly concerned with how others would respond to them given a general lack of understanding and acceptance of mental illness by others. This desire to promote understanding among others about their illness identities was illuminated in Billy's description of *Lifting the Veil* (presented in Chapter IV) in which he described his perceptions of how others viewed him given their lack of understanding and acceptance of mental illness as well as his desire to self-disclose to promote understanding and lift the "veil of ignorance and misunderstanding." The students who participated in Weiner's (1999) study shared similar concerns about self-disclosing a psychiatric disability in college and struggled to be understood with respect to their disabilities.

Self-disclosure was influenced by various conditions which acted to either encourage or inhibit the students' decisions to reveal a mood disorder while in college. It was important for participants to have established some sort of rapport with the recipients of their disclosures and to feel that they were trustworthy people who would respect their privacy and ensure that their disclosure information would



remain confidential. It was also important that the participants preserved control over their identities and control over the information they revealed to others regarding having a mood disorder. Through her research on self-disclosure among people with chronic illnesses, Charmaz (1991) found that individuals wanted to be known for attributes other than their illness and often would not disclose for fear that revealing their illness could impair others' images and judgments of them. This finding held true for the participants of this study who often guarded against self-disclosing a mood disorder until others got to know them better. This allowed people to get to know other important aspects of their identity and reduced the possibility that they would be solely defined or labeled by their mental illness.

To further understand how and when students make decisions to reveal or conceal a mood disorder, the participants described how self-disclosure typically occurs and shared particular aspects of self-disclosure which included the context in which it occurred, aspects of a personal style or approach, and a preferred method for revealing their illness identities. They preferred to self-disclose in private settings behind closed doors which helped to ensure their privacy and confidentiality, and shared that self-disclosure tended to be a one on one experience with another individual who they perceived would not divulge the disclosure information to others. The participants also revealed aspects of a personal style or approach to self-disclosure which they described as either casually introducing the topic during conversations or using a more direct approach by bluntly revealing their mood disorders. Their primary method of disclosure was to reveal information in person; however, two participants were only comfortable disclosing via electronic mail which

afforded them additional privacy and a sense of security. As the participants carefully selected how, where, and when to reveal a mood disorder, their main objective was to maintain an expectation with privacy and confidentiality. Derlega, Metts, Petronio, and Margulis (1993) addressed aspects of privacy regulation and vulnerability associated with self-disclosure and found that decisions to self-disclose depended on the degree of risk that a person perceived. Many factors contributed to the assessment of risk involved in disclosing personal information about oneself; in particular, maintaining confidentiality and ensuring privacy as well as having trust in the other person's discretion decreased risks associated with self-disclosure and increased the likelihood that a person would reveal private information about him or herself (Derlega et al.).

The following section explores additional factors that influenced the participants' decisions about self-disclosing a mood disorder while in college and connects the research findings to the second question which guided this study.

*What influences and factors have contributed to students' decisions about self-disclosing a mood disorder while in college?*

The factors and influences contributing to the participants' decisions about self-disclosing a mood disorder while in college included *Impact of Stigma*, *Perceived Campus Support*, and *Attributes of Personality*. In addition, the process of *Constructing an Illness Identity* influenced their decisions about self-disclosure.

*Impact of Stigma* greatly influenced the participants' decisions about self-disclosure. Participants mentioned stigmatization as a likely outcome of self-disclosure which left them feeling isolated and concerned about how others would

react to them as a result of their disclosures. Stigma influenced their decisions about when, where, and to whom to self-disclose a mood disorder. Although no participants cited an incident in which they experienced discrimination related to having a mood disorder, their awareness of mental illness stigma fueled their fears and led to a loss of self-confidence and heightened reluctance to self-disclose. A major concern shared among participants was that by disclosing a mood disorder, other aspects of their identities would be overshadowed, and because of stigma, they would not be seen as individuals.

Stigma was the most significant factor inhibiting the students' self-disclosures. Olivia summarized the concerns of all the participants in this study when she shared the following: "Stigma is the only consequence that could possibly occur if I disclose to someone . . . That is the only deterrent in disclosing to someone." Concern about stigma was reflected in several studies (Charmaz, 1991; Dougherty, Campana, Kontos, Flores, Lockhart, & Shaw, 1996; Schneider & Conrad, 1980; Weiner, 1996, 1999). Dougherty et al. (1996) reported that a significant source of anxiety and concern for students with psychiatric disabilities was their perception of stigma on campus and their fear of being labeled "mentally ill" by others. Students' perceptions of and actual experiences with stigma often inhibit their decisions to self-disclose a psychiatric disability on campus (Dougherty et al., 1996; Weiner, 1996, 1999). When the participants of this study experienced fear of being rejected and stigmatized for disclosing and for having an illness, they avoided disclosure entirely. Or, in some cases, in an attempt to preserve their identities and self-esteem and avoid leaving themselves open to mental illness stigma, the participants practiced selective

disclosure on campus – that is, they carefully decided when, where, and to whom to self-disclose their mood disorder to minimize the risk of experiencing stigma and discrimination.

*Perceived Campus Support* from faculty, staff, mental health service providers, and peers both with and without mood disorders contributed to the participants' decisions about self-disclosure. Students who perceived a high degree of support were more willing to self-disclose. Students who did not experience a high degree of support largely felt disconnected from campus and tended to conceal their mood disorders. Positive factors such as perceiving a high degree of support on campus decreased the participants' perceptions of stigma and their fears that disclosing their illness could impair others' images and judgments of them. As such, participants were encouraged to reveal their identities as people with mood disorders. And, they reported overwhelmingly positive outcomes when they experienced self-disclosure. Previous research on self-disclosure suggested that when individuals reveal themselves completely to others, they "live more authentically" (Jourard, 1971, p. v). The participants in this study revealed many positive outcomes of self-disclosure including eliminating their burden to keep a part of their identities hidden. Through self-disclosure, they felt "honest" and "open" with others and, in turn, were able to experience a genuine and authentic way of being in the world without carrying the heavy burden of concealing a mood disorder.

The participants largely felt supported on campus although they experienced certain challenges when navigating the university. For some, the size of campus contributed to feelings of isolation and made it difficult for them to make connections

with others. Weiner's (1999) research revealed that feelings of isolation increased for students with psychiatric disabilities who already felt isolated and insecure given their experience of difference on a campus that they described as "huge and impersonal" (p. 406).

It was interesting that five of the nine participants in this current study had self-disclosed a mood disorder to at least one faculty member and reported positive experiences which encouraged future disclosures. The four participants who had not revealed a mood disorder to any faculty felt uncomfortable opening up because of the formal nature of relationships with instructors and because they believed faculty were not educated about mood disorders and thus would be unsupportive. Previous research has shown a lack of acceptance among faculty members of students with mental illnesses (Amada, 1985, 1986, 1996, 1997; Becker, Martin, Wajeih, Ward, & Shern, 2002). Although this study didn't explore faculty perceptions, it is worth noting that some students perceived faculty as unsupportive, uninformed, and lacking acceptance of students with mood disorders and other psychiatric disorders.

Another finding which holds importance for student affairs educators is that participants largely were ambivalent about how staff members (described as anyone in a non-faculty role, including program directors, academic advisors, resident assistants, and so forth) contributed to their perceptions of campus support and to their decisions about self-disclosure. Only two participants shared positive experiences with staff members who supported them. The remaining seven participants were challenged to recall disclosure experiences with staff members and generally did not perceive a high degree of support from them. June remarked, "It

tells you that staff is irrelevant. I don't interact with them or it's very simple interaction. Why would I? Who would I disclose to?"

With regard to campus mental health services, the participants reported frustration with the process involved to secure appointments at the counseling and mental health centers and complained of long waiting lists and bureaucracy that hindered their ability to secure an appointment when in need. Although frustrated with procedures, the students largely felt support and encouragement from these services. Weiner (1999) reported that the students in his study felt that educational policies, practices, and procedures were obstacles for them as they navigated through the college environment. It is important that faculty, staff, and administrators understand how educational policies and procedures influence students' perceptions of campus support and their ability to self-disclose and receive support.

Participants stressed the importance of peers, those with and without mood disorders, as a significant source of support on campus. They described the importance of having friends and building connections with other students on campus and how these relationships shaped their self-disclosure process. Derlega, Metts, Petronio, and Margulis (1993) provided data that acknowledged the social benefits of self-disclosure which included obtaining empathy, advice, guidance, encouragement and motivational support. The participants in this study shared that self-disclosure was a vehicle for obtaining social support from peers and this support encouraged them to be open about having a mood disorder.

*Attributes of Personality* described personal characteristics that helped to shape each participant's experiences and reactions related to self-disclosing his or her

mood disorder. Self-disclosure was unique to each individual and was shaped by one's personal characteristics or personality. Despite extending multiple invitations for participants to speak about how aspects of their persona influenced their decisions about self-disclosure, their narratives did not elaborate on this issue beyond the findings previously described in Chapter IV. Additional research exploring the role of self is needed to further understanding for how individual and other internal factors influence the experience of having and self-disclosing a mood disorder.

Although self-disclosure was the focus of this study, the process of *Constructing an Illness Identity* was an interesting finding that merits continued exploration to understand how college students with mood disorders develop an illness identity and how this concept of identity informs self-disclosure as well as other phenomena related to their college experiences. Future research that explores this process would add greater clarity to understanding how students develop an illness identity and the degree to which it is integrated into their conceptions of self.

Upon receiving a diagnosis, the participants initiated a process of questioning and constructing the meaning of this new identity. Negotiating the meaning of their diagnoses led them to the process of *Constructing an Illness Identity* in which they described their point of view of mental illness, constructed and negotiated the meaning of their identities as people with mental illness, and expressed how their mood disorders impacted their lives.

Each participant engaged in a process of making sense of his or her diagnosis and the meaning it held for his or her conception of self. The participants struggled to make meaning of their identities given the potential threat that mental illness stigma

posed for them. Stigma was one of the most significant difficulties faced by the participants as they attempted to make meaning of their illness identities. The participants feared that their diagnoses, once known to others, would become the focal point of interactions with others and overshadow other salient aspects of their identities. Although some participants confirmed their acceptance of their illness identity to a greater extent than others did, all participants struggled to negotiate the meaning of their illness identities.

As the participants constructed and negotiated the meaning of their illness identities and grappled with factors such as stigma, perceived campus support, and attributes of their personalities, they varied in their decisions about self-disclosure. Some concealed their identities while others progressively became more comfortable and confident with this dimension of identity and with revealing information about having a mood disorder. This experience of *Constructing an Illness Identity* was an on-going process influenced by degree of acceptance of their mood disorder and contextual conditions that participants revisited at different points in their development. Factors such as time living with a mood disorder, increased self-awareness and understanding of a diagnosis, treatment plan, and support received from family and campus sources helped participants become more comfortable with decisions to reveal a mood disorder and make known their identity with respect to having a mood disorder.

The participants' narratives reflecting the key category *Constructing an Illness Identity*, relate to Deaux's (1993) research in social psychology, which conceptualized identity as "both defined internally by self and externally by others"



(Jones & McEwen, 2000, p. 406). Deaux (1993) considered “how individual motivations and experiences combine with social norms and situations to influence self-definition” and recognized that people construct their identities by making choices “both in identities that they claim and in the meanings and experiences associated with those identities” (p. 4). For participants of this study, the meanings that they associated with their illness identities differed at various points in their development and degree of acceptance of their mood disorder, which were influenced by both internal and external factors. The process of *Constructing an Illness Identity* was influenced by their disclosure experiences, the degree to which they had come to terms with a diagnosis, impact of stigma, perceived campus support, and attributes of personality. For example, students who had a family history of mental illness, and/or received positive messages from family about mental illness, and/or perceived a high degree of support on campus, associated more positive feelings about their identities as people with mood disorders, and were more likely to self-disclose. Yet, despite receiving support and positive messages, these students could still experience ambivalence about their illness identities in certain settings and situations. It is important to recognize the contextual influences on a student’s experience of *Constructing an Illness Identity* and understand that this process is fluid and one that can be revisited at various points in one’s life.

Erikson (1980), whose original work was published in 1959, conceptualized identity development as an internal process also shaped by external factors. Erikson (1980) described development as occurring through the resolution of identity crises (i.e., decision points). “A positive resolution of the identity stage results in a ‘sense

of identity' which is experienced personally, validated interpersonally, and formed in the context of cultural norms" (Widick, Parker, & Knefelkamp, 1978, p. 7). A positive sense of identity is developed when others confirm and validate how one views him or herself (Widick, Parker, & Knefelkamp, 1978). Jones (1996b), in a qualitative study of ten women college students exploring multiple dimensions of identity, suggested "the importance of seeing students as they see themselves or as they reveal themselves to others" (Jones & McEwen, 2000, p. 412). Research by Erikson (1980) and Jones (1996b) reflect the experiences of the participants in this study who wanted to be understood with respect to having a mood disorder and viewed as individuals with multiple salient identities. One of their major concerns about self-disclosure was that knowledge of a mood disorder would overshadow other important aspects of their identities. The following quote, written in reference to the participants of Jones's (1996b) study, captured the essence of the experiences of the students in this current study who were engaged in the on-going process of *Constructing an Illness Identity*. Given the participants' concerns about mental illness stigma and their perceptions that revelation of a mood disorder would overshadow other salient aspects of their identities, they "wanted to be understood as they understood themselves and as the totality of who they were, rather than be understood through externally imposed labels and by a singular dimension" (Jones & McEwen, 2000, p. 412).

The findings of this study hold promise for the development of additional research that explore and unveil information related to self-disclosure for college students with mood disorders and the design of models that depict this process.

### Limitations of the Study

Although the purpose of this study was to explore self-disclosure for students with mood disorders and not to generalize from the experiences of the research participants, there are limitations to this research which must be considered.

Although psychiatric disabilities include a broad range of diagnoses such as mood disorders, schizophrenia, anxiety disorders, and personality disorders, this research focused on the experiences of college students diagnosed with either bipolar disorder or major depressive disorder and did not claim to address experiences of students with other psychiatric disabilities.

Based on the data gathered in this study, self-disclosure for college students with mood disorders is a complex process unique to each individual and shaped by his or her college and pre-college life experiences, and cannot be fully explored and understood through the findings and interpretations of one research study of nine participants.

Some participants shared that they had not given much thought and attention about how they made decisions about self-disclosure. The participants' degree of self-awareness related to having a mood disorder likely impacted their ability to recall and share stories related to self-disclosure and to ascribe meaning to their narratives.

The context of the large, Mid-Atlantic university, the research site selected for this study, with its size, geographic location, and culture influenced individual perceptions and behaviors related to students with mood disorders. Conducting this research at another university environment, different in size, geographic location, or

culture may contribute additional insights, understandings, and considerations regarding students with mood disorders and their self-disclosure process.

In qualitative inquiry, the researcher is the data-gathering instrument and poses the risk of potential bias (Lincoln & Guba, 1985). The risk for this study was that my own perceptions and experiences related to the phenomenon of study influenced the data collection and interpretations. The use of peer debriefers and member checks as well as an inquiry auditor provided feedback and confirmation of emerging interpretations which decreased the risk of potential bias.

There was a significant lack of diversity in race, ethnicity, social class, sexual orientation, and religion/faith among participants. This study also reflected the voices of those students who indicated an interest in, and were reasonably comfortable with, talking about their mood disorder, and did not include those students who were unwilling to take part in this kind of research and openly identify themselves as persons with mood disorders. Because of these lack of representations, the voices and experiences of those identities not incorporated in this study are notably absent in the findings and interpretations of this inquiry.

Despite these conditions, this research provides a significant contribution to student affairs by raising awareness for how students make decisions about self-disclosing a mood disorder while in college. The inclusion of participants' voices in this research cannot be understated; their narratives contributed richness to this inquiry. This study provides directions for student affairs practice and a foundation for future research which examines and describes this phenomenon.

## Implications and Recommendations for Practice

The theory that emerged from this research offers a framework for understanding how students with mood disorders make decisions about self-disclosure while in college. The findings of this study suggest important recommendations for how students, faculty, and staff may best demonstrate support for college students with mood disorders in the effort to positively influence their self-disclosure experiences as well as to promote the development of more inclusive and hospitable environments for these students. This section explores recommendations for creating intentional environments that meet the educational and developmental needs of students with mood disorders and assisting them as they make decisions about self-disclosure.

Student development theories (Evans, Forney, & Guido-DiBrito, 1998; Evans, 2003; McEwen, 2003) provide frameworks for understanding students' psychosocial, moral, and cognitive development but fail to include the voices of students with mood disorders and other psychiatric disabilities. Educators, including student affairs administrators and faculty, cannot presume to know the needs of these students until there are more opportunities to give voice to students with mood disorders and permit them to articulate their educational and developmental needs. The participants of this study cited stigma as a barrier to self-disclosure which led them to perceive degrees of nonsupport on campus, invariably creating the perception of an unwelcoming environment. Educators must understand the influences of such experiences as being marginalized and isolated on campus and explore what practices and services can be

implemented to provide support for students and their self-disclosure experiences. Examples of support are further described in this chapter.

Little research has been conducted in higher education that explores the perceptions, concerns, and experiences of students with mood disorders and other psychiatric disabilities. As a result, there is little understanding of what issues and challenges these students experience on their college campuses in relation to self-disclosure. Perhaps the lack of research focusing on college students with mood disorders and other psychiatric disabilities is a reflection of the stigma and negative assumptions about people with mental illness, or the perception that psychiatric disabilities are purely clinical and medical concerns to be addressed exclusively by campus counseling and mental health centers, and not related to educational equity and inclusion or sociocultural experiences. As student affairs educators, we need to spend more time listening to students and creating opportunities for them to dialogue and share their stories related to having and disclosing a mood disorder in college. Information about how these students interpret and make meaning of the messages they receive about mood disorders can be used to prompt student affairs practitioners and faculty to develop programs, policies, and services designed to meet the needs of this population. The responsibility rests with all faculty, staff, and administrators, not just those units whose particular focus is mental health services.

Colleges and universities must create environments that foster respect and a basic sense of safety around issues of mood disorders and give students opportunities to build self-awareness and increase their confidence related to having and disclosing a mood disorder while in college.

Advocacy efforts in addition to clinical and medical support provided by campus counseling and health centers are critical for promoting supportive environments for these students. For example, institutions and their students would greatly benefit from the creation of a mental health resource and advocacy center. The center, which should be centrally located in a highly frequented, highly visible place on campus such as the student union, should focus on students and their sociocultural experiences related to having and disclosing a mood disorder. This resource would provide support to students to explore and further understand their mood disorders outside of the traditional clinical settings of a campus health center or counseling center which are typically designed, equipped, and funded to provide short-term services. The resource and advocacy center could also provide opportunities to raise awareness, understanding, and knowledge about mental illness among students without these disabilities. Education offered through the resource center would encourage dialogue among students and promote tolerance by sending the message that mental illness is not a taboo subject. As research has documented (Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Desforges, Lord, Ramsey, Mason, Van Leeuwen, West, & Lepper, 1991; Link & Cullen, 1986; Wahl, Briggs, & Zastowny, 1980), increasing the public's familiarity with mental illness through personal contact with people who have these disorders decreases mental illness stigma and social distancing responses toward persons with mental illness.

Through opportunities on campus that raise awareness for, and increase understanding of, students with mood disorders, institutions promote the creation of safe and inclusive environments for students with mood disorders. In addition, they

provide opportunities for students, faculty, and staff to learn more about the needs of this student population. Examples of such initiatives could include the creation of an existing institution-wide committee examining issues related to students with mood disorders and other psychiatric disabilities, awareness programs that educate the campus community about the existence and prevalence of mood disorders in college, residence hall programs that encourage dialogue and promote tolerance, and peer support groups and other programs focused on the needs of students with mood disorders. Programs such as these would encourage the formation of inclusive and welcoming environments, and ultimately provide support for students identifying as having a mood disorder.

Colleges and universities can also demonstrate further support for students with mood disorders by encouraging members of the campus community to identify themselves as allies through a campus initiative that displays “safe space” or “safe zone” signs in offices throughout campus (similar to those already used to support lesbian, gay, bisexual, and transgender students, but designed with language that specifies support for students with mood disorders and other psychiatric disabilities). This symbol of support invites students to self-disclose a mood disorder and supports them in their decisions to openly identify this dimension of their identities. In addition, campuses should develop education and training programs and services for allies to increase their understanding for the needs of college students with mood disorders and other psychiatric disabilities. These programs could describe symptoms of these disorders, outline research on mental illness stigma, provide information about counseling and mental health services and other support programs, and draw



upon the experience of students with these disorders as well as the expertise of mental health professionals and educators.

Regarding its support services, institutions must also consider new ways in which students can learn about, access, and gain entry to mental health services and other support programs. Participants of this study perceived different levels of support from campus mental health services. Many were challenged to navigate the bureaucracy and length of time involved in securing appointments at the counseling and mental health centers, some were unaware of services and programs offered, and others reported knowledge of existing programs but felt they were not well advertised. Additionally, not all participants were aware that they could qualify for academic accommodations through disability support services. Involving key units on campus such as orientation programs, residence life, and academic advising in efforts to disseminate information about support programs and services would increase students' awareness for resources available to them and better assist them in gaining support.

Lynch and Gussel (1996) suggested that without training, institutional support, and contact with persons with disabilities, faculty members are less likely to possess positive attitudes toward persons with disabilities. Therefore, education of faculty about mental illness is also critical for promoting attitudinal change and creating supportive environments for students with mood disorders. Faculty must be educated to recognize symptoms of mood disorders, become aware of support services, and make appropriate referrals. This basic knowledge of symptoms and awareness of mental health services and other sources of support for students

facilitate appropriate referrals and ensure that their needs are met. Additionally, to encourage meaningful dialogue among faculty and students and to foster a safe and welcoming environment for students, faculty must take time to discuss disability issues when reviewing information on the syllabus in class and invite students to disclose their mood disorder and seek support.

Further, colleges and universities can provide on-going professional development workshops for faculty and staff that teach counseling skills to nurture sensitivity and empathy for students with mood disorders and that focus on strategies to assist students who seek academic accommodations and other forms of support. These workshops would be especially important for staff members since the participants of this study were largely unaware of the role staff members (described as anyone in a non-faculty role, including program directors, academic advisors, resident assistants, and so forth) could play in their college development. Thus, they rarely perceived staff as sources of support on campus.

Creating opportunities for students' self expression among peers would also help students feel a better connection to the community and decrease their isolation on campus. The participants in this study repeatedly cited mutual disclosure as a factor that encouraged their self-disclosure, demonstrating the need for interactions with others. David and Olivia also stressed the need for interaction with other students with mood disorders and identified the bipolar support group as a significant source of support on campus. Colleges and universities can demonstrate a commitment to providing supporting and affirming communities for students with mood disorders by establishing safe places for students to meet and connect with their

peers who also have mood disorders. According to Strange (2000), “conditions of community thrive when space is available for a group of individuals who share common characteristics and interests” (p. 27). Support groups and dialogue programs present students with important opportunities to identify and connect with their peers and develop their own sources of community on campus.

In an effort to increase opportunities for student interaction, higher education institutions should also consider building partnerships with national mental health associations to develop a presence on campuses. For example, the National Alliance for the Mentally Ill (NAMI) offers support groups organized and facilitated by people with mental illnesses. This model of a peer support group could be implemented in college settings to encourage community among students with mood disorders.

The participants in this study described particular characteristics they sought in recipients of their disclosures (e.g., trustworthy, nonjudgmental, etc.). They also spoke about the impact peer influence had on their decisions to self-disclose a mood disorder. Their need for inclusion and acceptance impacted the extent to which they revealed their identities as people living with mood disorders. Efforts to educate all students about mood disorders and to challenge mental illness stigma on campus are essential to the ability of institutions to promote safety and inclusion for students with mood disorders as well as to support their self-disclosure experiences.

This study also provides implications for how institutional research and student assessment are conducted. When reviewing assessment tools and program evaluations, it is important to consider and include students with mood disorders and other psychiatric disabilities. Conducting interviews and focus groups with students

with mood disorders, a commonly hidden and otherwise invisible population, would give them voice and provide them opportunities to describe their experiences in their own words. Through careful attention to their experiences as described by the students themselves, educators could create better policies, procedures, programs, and services that encourage the growth and development of students with mood disorders.

These recommendations suggest ways in which faculty, staff, and administrators may create environments that welcome students to self-disclose their mood disorders in college and to seek support and affirmation. As student affairs educators we need to make ourselves aware of the existence and prevalence of students with mood disorders and their experiences, and we need to provide support for these students in the effort to positively influence their self-disclosure experiences.

#### Implications for Future Research

This study utilized a qualitative mode of inquiry to explore the research questions. The grounded theory methodology was selected to explore how and when students decide whether or not to self-disclose a mood disorder in college and the factors and influences that encourage or inhibit their decisions. The nature of qualitative inquiry does not aim to produce generalizations; instead, researchers present data through “thick description” (Lincoln & Guba, 1985, p. 316). These in-depth, communicative descriptions of the experiences of the participants relative to self-disclosure are provided to enable other researchers to make informed decisions regarding the appropriateness of transferability to other settings. Findings from the current study *Lifting the Veil on Invisible Identities* present many opportunities for

further research. Although this study raises awareness about the self-disclosure process, more studies are needed to continue to develop a better understanding of such experiences. This section examines suggestions for future research directions.

A grounded theory study exploring self-disclosure and the intersections of social identities including race and ethnicity, gender, sexual orientation, social class, religion/faith, as well as other psychiatric disabilities would help to increase understanding about the role and influence of identity integration in students' decisions about self-disclosing a mood disorder. Another potential study could explore race, ethnicity, and religion/faith to understand how cultural norms may influence perceptions and beliefs about mental illness and the appropriateness of seeking help (e.g., counseling, therapy) outside of one's community (Helms & Cook, 1999; Jenkins, 1999).

Using grounded theory study to explore the process of constructing an illness identity provides another promising area of research. Understanding how illness identity is developed and the degree to which it is integrated into students' conceptions of self may generate new thinking about student development theory, policy, and practice related to students with mood disorders. Additionally, exploring the intersections of illness identity with other dimensions of identity (e.g., race/ethnicity, gender, sexual orientation, social class, religion/faith, etc.) creates another research possibility.

A longitudinal study of the students who participated in this study using a qualitative approach would be an important direction for future research. Follow-up studies of the participants after graduation would add another dimension to faculty,

staff, and student knowledge of the factors that influence self-disclosure. It would be interesting to explore the self-disclosure process in a new environment such as graduate school or an employment setting. Would the factors that influenced self-disclosure in college remain the same or differ in other settings? Future longitudinal studies could answer this and other questions and provide additional data to further develop a model of self-disclosure.

Conducting a study that focuses on examining what students with mood disorders have to say about their experiences of stigma would enhance public and professional understanding about the impact of stigma on decisions about self-disclosure as well as the influence of stigma on educational experiences and outcomes. Since little is known about perceptions, concerns, and experiences of these students on college campuses, research that explores perceptions of campus climate is critical to understanding the college experiences of students with mood disorders. Information about how students with mood disorders interpret and make meaning of the messages they receive about mood disorders can be used to prompt student affairs practitioners and faculty to develop programs and policies designed to meet the needs of this population.

Other areas for potential research include: exploring the impact of time of diagnosis on self-disclosure to understand how this influences students' adaptability and ability to seek out resources needed to succeed in college and manage their illness; investigating differences in experiences among students who had positive family support and those who lacked this support and received negative messages about having a mood disorder; and exploring the invisible nature of mood disorders

and how the experience of having an illness may parallel the experiences of lesbian, gay, bisexual, and transgender students who may view sexual orientation as a hidden and otherwise invisible social identity to understand how that sense of invisibility can be a place of safety and other times mean isolation for students.

In an effort to guide the design of programs and services for students with mood disorders, it is important that student affairs professionals in all service units understand the needs of these students and work on their behalf to ensure they receive appropriate direction, guidance, and resources, and support. This is critical to the ability of institutions to create intentional environments that better meet the educational and developmental needs of this student population.

Another consideration for future research involves studying various campus departments and offices (units whose focus is not providing mental health services) to assess how well-equipped and trained they are to address the needs of students with mood disorders. For example, what is the level of awareness in the Greek system? What level and form of training does residence life staff receive? How prepared are academic advisors to respond to the needs of students with mood disorders? Future studies on these and related topics could reveal information to assist educators in creating programs and services tailored to the specific needs of these students.

Future studies using different paradigms and modes of inquiry (i.e., quantitative research, case study, ethnography, and phenomenology) could also be used to explore and examine different questions and dimensions of self-disclosure and to expand the scope of research to include other phenomena related to college students with mood disorders. For example, using phenomenology to explore how

students with mood disorders conceptualize the world around them presents an opportunity for future research. A phenomenological study focused on exploring the “lived experience” of having a mood disorder in college may reveal more in-depth information about self-disclosure as well as the experience of navigating through college with a mood disorder. Ethnography or case study research could be used to study the culture of college students living with mood disorders. For example, a study that focused on self-disclosure or another phenomenon related to experiencing a mood disorder in college (e.g., experiencing stigma) might take place at the mental health center’s bipolar support group. Rich insights into this particular culture would be gained through observing the behavior of a small group of students and exploring the culture of the support group in its natural setting and as the members perceive it.

Finally, conducting a campus climate study which focuses on faculty, staff, and student perceptions of people with mood disorders and other mental illnesses would reveal what knowledge members of the campus community have (or lack) about mental illness and how they define and identify people with these disorders. The information gathered on their perceptions of, and levels of awareness for, mental illness would uncover how public perceptions of mental illnesses influence the development of policy and practice in higher education and the ability of educators to create inclusive and hospitable environments for these students.

All of these are examples of potential future research initiatives that would further faculty, staff, and student understanding of the needs of college students with mood disorders and help colleges and universities promote the creation of environments that welcome, nurture, and sustain their development and educational



pursuits. It is critical that educators continue to develop and conduct research studies like these in order to find the best ways possible to help students with mood disorders to ultimately succeed in college.

### Strengths of the Study

The strengths of this study include the nature of the inquiry and the data collection and analysis processes. Using a qualitative mode of inquiry, this study explored self-disclosure from the perspective of the students. Their voices shaped the findings and added a much-needed richness to faculty, staff, and student understanding of the experience of college students diagnosed with mood disorders. This research raises awareness for a phenomenon that remains generally unknown in student affairs and higher education and that represents the often silent and otherwise invisible voices and experiences of the participants.

Another strength of this study rested on the researcher's efforts to establish the integrity and trustworthiness of this research. As an integral part of data collection, the researcher developed and maintained rapport with the participants and affirmed each participant as a valued contributor to this study. Establishing rapport encouraged the participants to feel comfortable discussing and disclosing information related to their mood disorder and enhanced the depth and richness of the research findings.

The depth of the interviews gave credibility to the findings and interpretations. Through three interviews with each participant, sufficient data were collected and analyzed to fully explore and develop emerging categories that were integrated, refined, and grounded in the data to generate a grounded theory. The

researcher followed the systematic approach of data analysis and the prescribed coding process to describe the self-disclosure process and unveil the factors influencing students' decisions about self-disclosure. Additionally, this study employed the strategies of prolonged engagement, triangulation, peer debriefing, and member checks to achieve the criterion of credibility and help to ensure researcher sensitivity. An inquiry auditor substantiated the authenticity of the study and dependability of the final analysis.

### Conclusion

This study *Lifting the Veil on Invisible Identities* explored and described self-disclosure for nine undergraduate students diagnosed as having bipolar disorder or major depressive disorder. The research provided an examination of how students made decisions to reveal or conceal a mood disorder while in college and the factors and conditions that encouraged and inhibited their decisions. This study presented rich descriptions related to the phenomenon of study reflecting the voices of the participants

The findings and interpretations of this study offer new directions for practice and recommendations for future research that reflect the needs of this population as identified by the students themselves. By exploring the emergent theory, educators can draw attention to the influences that shape decisions about self-disclosure, and use this knowledge to support college students with mood disorders and positively influence their self-disclosure experiences, as well as to create supportive and inclusive environments for these students. Through listening to student experiences

and giving them voice, this research increases visibility for this hidden and rarely addressed student population.

Appendix A  
Letter of Invitation for Student Research Participation

Date

Dear Student:

Hello! My name is Partamin Farzad Nawabi. I am a doctoral candidate at the University of Maryland conducting dissertation research with college students diagnosed with a psychiatric disability. My research examines critical incidents (i.e., significant people, places, and events) in the college environment which contribute to students' decisions to self-disclose a psychiatric disability. I would like to talk to you about how your experiences at the University of Maryland have influenced your decisions regarding self-disclosing a psychiatric disability.

If you are interested in participating in this study, you should be a current undergraduate student enrolled at the University of Maryland and diagnosed by a psychiatrist with bipolar disorder or major depressive disorder. Your commitment in this study requires at least three interviews during the fall 2002 semester, which are scheduled at your convenience. Each interview lasts approximately 60-90 minutes. In appreciation of your involvement and contributions, you will receive a \$25 gift certificate from Target stores at the completion of the study.

Please be assured that I will respect and maintain your anonymity throughout the research process. To protect your privacy and anonymity, you will not be identified by your name to anyone or in any written material. To ensure your confidentiality, you will be asked to select a pseudonym of your choice. Your participation in this research is strictly voluntary and you may choose to withdraw at any time during the study.

I hope you will consider participating in this research. Your input would be very valuable to this research. Through your contributions, awareness, knowledge, and understanding of the needs of college students with psychiatric disabilities will be heightened. In addition, important improvements related to those needs may be revealed, and recommendations made to enhance the college experiences for all students with psychiatric disabilities.

If you are interested in participating in this study, please complete the attached research interest form and return it to me. I am happy to respond to any questions or concerns that you may have about participating in this study. I can be reached by phone: (301) 774-0052 (home – shared answering machine) or (301) 405-7567 (work – private voice mail), or via email: [pf54@umail.umd.edu](mailto:pf54@umail.umd.edu).

I look forward to speaking with you and appreciate your interest in this study.

Many thanks,

Partamin Farzad Nawabi  
Doctoral Candidate  
Department of Counseling and Personnel Services  
University of Maryland

## Appendix B

### Letter to Gatekeepers

Date

Dear Faculty/Staff:

Hello! My name is Partamin Farzad Nawabi. I am a doctoral candidate at the University of Maryland conducting dissertation research with college students diagnosed with a psychiatric disability. My research examines critical incidents (i.e., significant people, places, and events) in the college environment which contribute to students' decisions to self-disclose a psychiatric disability.

I am seeking participants for my study who are current undergraduate students enrolled at the University of Maryland and diagnosed by a psychiatrist with bipolar disorder or major depressive disorder. Students' commitment in this study requires at least three interviews during the fall 2002 semester, which are scheduled at their convenience. Each interview lasts approximately 60-90 minutes. In appreciation of their involvement and contributions, participants will receive a \$25 gift certificate from Target stores at the completion of the study.

Please be assured that I will respect and maintain participants' anonymity throughout the research process. To protect their privacy and anonymity, participants will not be identified by name to anyone or in any written material. To ensure their confidentiality, participants will be asked to select a pseudonym of their choice. Participation in this research is strictly voluntary and participants may choose to withdraw at any time during the study.

Student input would be very valuable to this research. Through student's contributions, awareness, knowledge, and understanding of the needs of college students with psychiatric disabilities will be heightened. In addition, important improvements related to those needs may be revealed, and recommendations made to enhance the college experiences for all students with psychiatric disabilities.

I would appreciate you sharing both the enclosed research interest form and letter inviting student participation in my study with any student diagnosed with a psychiatric disability and enrolled at the University of Maryland. Please contact me by phone: (301) 405-7567 or via email: [pf54@umail.umd.edu](mailto:pf54@umail.umd.edu) should you have any questions.

Thank you very much for your assistance.

Sincerely,

Partamin Farzad Nawabi  
Doctoral Candidate  
Department of Counseling and Personnel Services  
University of Maryland

Enclosed

Appendix C  
Flier

**SEEKING STUDENT PARTICIPANTS FOR  
FALL 2002 DISSERTATION RESEARCH  
EXPLORING**

**“Invisible Identities: Critical Incidents  
Contributing to Self-Disclosure for  
Students with Psychiatric Disabilities  
in College”**

PLEASE CONSIDER PARTICIPATING IF YOU ARE:

- An undergraduate who is currently enrolled at the University of Maryland; and
- Diagnosed with bipolar disorder or major depressive disorder

PARTICIPATION IN THIS STUDY INVOLVES:

- Three individual interviews scheduled at your convenience (if appropriate, additional interviews may be conducted)

*Interviews will be conducted in a private campus office by Partamin Farzad Nawabi. To ensure confidentiality, participants choose their own pseudonyms and will not be identified by their actual name to anyone verbally or in written material. In appreciation for their involvement, participants will receive a gift certificate to Target.*

---

**For more information and to express interest in this study, please contact:**

Partamin Farzad Nawabi  
Doctoral Candidate  
Counseling and Personnel Services Department  
University of Maryland  
(301) 405-7567 (work – private voice mail)  
Email: pf54@umail.umd.edu

## Appendix D

### Research Interest Form

#### Research Description

This is a research study conducted by Partamin Farzad Nawabi, a doctoral candidate at the University of Maryland at College Park. The purpose of the study is to explore significant experiences that have influenced self-disclosure for undergraduate students with psychiatric disabilities in college. Participants need to be currently enrolled at the University of Maryland and diagnosed by a psychiatrist with bipolar disorder or major depressive disorder.

#### Are You Interested?

\_\_\_\_\_ YES, I am diagnosed with bipolar disorder or major depressive disorder and am interested in participating in the research study described above which will be conducted by Partamin Farzad Nawabi during the 2002 Fall Semester.

Signature \_\_\_\_\_ Date \_\_\_\_\_

.....  
Please complete the following information:

NAME: \_\_\_\_\_

ADDRESS (local or campus): \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NUMBER(S): \_\_\_\_\_

If this is a telephone number with a shared answering machine or voice mail, may I leave a message?

YES \_\_\_\_\_ NO \_\_\_\_\_

EMAIL: \_\_\_\_\_

Preference for how to be reached: \_\_\_\_\_

#### Demographic Information:

YEAR IN COLLEGE: \_\_\_\_\_

COLLEGE MAJOR: \_\_\_\_\_

AGE: \_\_\_\_\_

GENDER: \_\_\_\_\_

RACE: \_\_\_\_\_

ETHNICITY: \_\_\_\_\_

SEXUAL ORIENTATION: \_\_\_\_\_

SOCIOECONOMIC STATUS: \_\_\_\_\_

RELIGIOUS/SPIRITUAL AFFILIATION: \_\_\_\_\_

CLINICAL DIAGNOSIS: \_\_\_\_\_

DATE OF DIAGNOSIS: \_\_\_\_\_

WHO MADE THE DIAGNOSIS? \_\_\_\_\_

.....  
**Please return this form to:**

Partamin Farzad Nawabi  
Office of Human Relations Programs  
1130 Shriver Laboratory, East Wing  
College Park, MD 20742

**Or contact me directly:**

(301) 774-0052 (home - shared answering machine)  
(301) 405-7567 (work - private voice mail)  
Email: [pf54@umail.umd.edu](mailto:pf54@umail.umd.edu)

## Appendix E

### Informed Consent

Initials \_\_\_\_\_ Date \_\_\_\_\_

PROJECT TITLE: Invisible Identities: Critical Incidents Contributing to Self-Disclosure for Students with Psychiatric Disabilities in College

INVESTIGATOR: Partamin Farzad Nawabi

I am over eighteen years of age and wish to participate in a program of research being conducted by Partamin Farzad Nawabi at the University of Maryland at College Park, Department of Counseling and Personnel Services.

I understand that the purpose of the study is to explore significant experiences that have influenced self-disclosure for undergraduate students with psychiatric disabilities in college. I understand that the research involves audiotaping of interviews. I also understand that the open-ended interviews will focus on my experiences as a college student with a psychiatric disability, related to self-disclosing my illness.

Interviews will be conducted in a private office on campus by Partamin Farzad Nawabi. Three interviews are planned, and are expected to last 1 to 1 1/2 hours each. I understand that, if appropriate, additional interviews may be conducted. I also understand that I will be given copies of my interview transcripts for my review and comments. I understand that members of the research team may review transcriptions of interviews. Tapes from interviews will only be heard by the researcher and will be securely stored in a locked drawer in the researcher's office. Tapes will be destroyed within a year of the completion of the study.

I understand that to ensure confidentiality, I will choose my own pseudonym and will not be identified by my actual name to anyone verbally or in written material. The researcher will maintain confidentiality by numerically coding the audiotapes and transcribing and coding the interviews using participants' pseudonyms. Excerpts of the interviews may be used in the written reporting of this study, but I understand that my actual name will not be used. I also understand that there remains a remote possibility based on what is subsequently reported in the study, that participants may still be identified by individuals who read the study and recognize them through their disclosures. I understand that as stated, this possibility is remote and every safeguard within the purview of the researcher will be taken to protect against such from occurring. I understand that the researcher will take every reasonable precaution to respect and to ensure participants' confidentiality. However, I am informed that Ms. Farzad Nawabi cannot safeguard my confidences that indicate harm to self or to others or



Initials \_\_\_\_\_ Date \_\_\_\_\_

that reveal current sexual abuse or incest. Should these circumstances be revealed during the research process, I understand that she will share the information with a staff psychologist at the campus counseling center.

I understand that this study is not designed to help me personally, but rather that the researcher hopes to learn more about the experiences of college students with psychiatric disabilities. I understand that in discussing my experiences, I may come to a deeper understanding of myself as an outcome of my participation in this research. I understand that the risk involved in discussing past and present experiences related to my psychiatric disability is that some experiences may become more sharply focused than previously and that further self-awareness may be anxiety producing. If this should occur, I understand that I may inform Ms. Farzad Nawabi and seek her assistance for obtaining appropriate support. I acknowledge that I received a resource handout outlining campus and community counseling, psychiatric, and advocacy resources. I understand that I may obtain support by contacting Dr. Jonathan Kandell of the campus counseling center, Dr. Jerome Kaufman of the campus mental health services, or the health care professional who is managing my treatment program. I understand that my participation is voluntary and that I am free to ask questions or to withdraw at any time without penalty.

The University of Maryland does not provide any medical or hospitalization insurance for participants in this research study nor will the University of Maryland provide any compensation for any injury sustained as a result of participation in this research study, except as required by law.

I understand that Ms. Farzad Nawabi is conducting this research under the supervision of Dr. Marylu McEwen, Associate Professor of Counseling and Personnel Services at the University of Maryland. I understand that I may contact Ms. Farzad Nawabi and Dr. McEwen at:

Partamin Farzad Nawabi  
Office of Human Relations Programs  
1130 Shriver Laboratory, East Wing  
College Park, MD 20742  
(301) 405-7567 (work phone with private voice mail)  
(301) 774-0052 (home phone with answering machine which others may hear)  
Email: pf54@umail.umd.edu

Dr. Marylu McEwen  
Counseling and Personnel Services  
3214 Benjamin Building  
College Park, MD 20742  
(301) 405-2871 (work phone with private voice mail)  
Email: mm41@umail.umd.edu

**Name of Participant (please print):** \_\_\_\_\_

**Signature of Participant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Appendix F  
Interview Protocol

(Notes for Researcher)

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**I. OBSERVATION OF THE SETTING**

Where

When

Other people present

Overall impression of the mood/atmosphere

**II. DEMOGRAPHIC INFORMATION (duplicate information from the research interest form that may need further clarification)**

Year in College

College Major

Age

Gender

Race

Ethnicity

Sexual Orientation

Socioeconomic Status

Religious/Spiritual Affiliation

Clinical Diagnosis

Date of Diagnosis

Diagnosed by Whom

- III. *As you know, the purpose of this study is to explore and understand the significant experiences which have influenced self-disclosure for undergraduate students with psychiatric disabilities in college.*

*I am going to start the tape recorder now. Please feel free to ask me to stop the tape at any time.*

#### INTERVIEW I:

1. Please tell me a little about yourself and why you chose to participate in this study.
2. What does it mean for you to have bipolar disorder or major depressive disorder?
3. When and where do you self-disclose your psychiatric disability?
4. Please describe how you disclose your illness.
5. When and to whom have you self-disclosed your illness? Does this include anyone on campus? What was the context (the setting or the situation) for this event or interaction? How would you describe your relationship with the recipient(s) of your disclosure?
6. How do you make decisions about self-disclosure? How do you decide to whom to disclose your illness?
7. What concerns do you have about how others respond to your disclosures? Briefly describe.
8. How have individuals within the university setting supported you as a person with a psychiatric disability?
9. How has this support influenced your decisions about self-disclosure?
10. How have individuals within the university setting not supported you as a person with a psychiatric disability?
11. How has this lack of support influenced your decisions about self-disclosure?
12. As we wrap up, are there other experiences that may have come to mind?
13. Is there anything that you would like to add or feel I should have asked you?

#### SUBSEQUENT INTERVIEWS:

Review transcript from previous interview:

1. What was it like to read the transcript?
2. Would you add/change anything to the transcript?
3. How do you believe these experiences are connected, if at all?

Ask follow-up questions noted on the transcript . . .

#### LIST OF POTENTIAL QUESTIONS TO ASK:

4. Please describe briefly a positive event, interaction or place that occurred on campus that encouraged you to self-disclose your psychiatric disability. If the event or interaction involved another person, identify who that person was.
5. What was the context (the setting or the situation) for this event or interaction?
6. What made this event/interaction important for you? (Describe briefly).
7. Please describe briefly a negative event or interaction that occurred on campus that discouraged you from self-disclosing your psychiatric disability.

8. What was the context (the setting or the situation) for this event or interaction?
9. In what way did each of these experiences (positive or negative) affect/influence your decisions to self-disclose your illness?
10. What is it about each experience that makes it “critical” in your experience? What meaning does each have for you?
11. If you have not disclosed your illness to anyone on campus, please tell me more about the experiences which stand out for you during your college experience which you believe significantly affected your decision not to disclose your illness (these are often called critical incidents and may be significant people, places, or events).
12. What is it like identifying as a person with a psychiatric disability at the University of Maryland?
13. What does it mean for you to disclose to others that you have a psychiatric disability? What does non-disclosure mean to you?
14. Describe what has been significant to you about this campus as it relates to your psychiatric disability.
15. Have there been particular experiences on campus which have directly or indirectly influenced your decisions about self-disclosure in college?
16. What is it like not to disclose your disability on campus? What is it like to self-disclose on campus?
17. What is it about being a student at Maryland that is most significant as it relates to you making decisions about self-disclosing a psychiatric disability?
18. As you have reflected on these critical experiences, how do they all fit together for you?

Review/discuss documents you brought to share . . .

1. Why did you choose these particular documents?
2. What meaning do these documents have for you?
3. As wrap up, are there other experiences that may have come to mind?
4. Is there anything that you would like to add or feel I should have asked you?

Appendix G  
Transcript Cover Letter

Date

Dear Student:

Thanks again for your participation in my research study. I have enclosed a copy of the transcript of our most recent interview for your review and comments. Please read it carefully and note if I have missed something or if you have additional thoughts, ideas, or insights. Please write your reflections in the margins of this transcript or attach additional pages if you prefer.

Once you have completed the review, please contact me by phone: (301) 405-7567 (work phone with private voice mail) or (301) 774-0052 (home phone with answering machine which others may hear) or via email: [pf54@umail.umd.edu](mailto:pf54@umail.umd.edu). We can then schedule a time to review your comments in person. I would appreciate you returning the transcript to me with your comments at our next meeting.

Thanks again for your willingness to give your valuable time to my study. I really enjoyed talking with you and I look forward to hearing from you soon. Please do not hesitate to contact me with any questions or concerns.

Many thanks,

Partamin Farzad Nawabi  
Doctoral Candidate  
Department of Counseling and Personnel Services  
University of Maryland

Enclosed

Appendix H  
Campus and Community Resource Handout

**Campus Resources:**

Partamin Farzad Nawabi: (301) 405-7567 (work phone with private voice mail);  
(301) 774-0052 (home phone with answering machine which others may hear);  
pf54@umail.umd.edu

**Counseling Services:**

Dr. Jonathan Kandell, Assistant Director & Head of Counseling Service  
(301) 314-7651

**Psychiatric Services:**

Dr. Jerome Kaufman, Director of Mental Health Services  
(301) 314-8106

**Support and Advocacy Organizations:**

American Council on Education (ACE) "HEATH Resource Center" -- The national clearinghouse on postsecondary education for individuals with disabilities.  
Email: [HEATH@ace.nche.edu](mailto:HEATH@ace.nche.edu) or Web: [www.acenet.edu](http://www.acenet.edu)

The Depression and Related Affective Disorders Association (DRADA)  
Johns Hopkins Hospital  
Baltimore, MD  
<http://infonet.welch.jhu.edu/departments/drada/default>

National Alliance for the Mentally Ill (NAMI)  
Arlington, VA  
<http://www.nami.org>

National Mental Health Association (NMHA)  
Alexandria, VA  
<http://www.nmha.org>

**Reading Material:**

Bloise, P. (1999). *Dancing with the serpent: Diary of madness*. New York: Cas Ananda Publishing.

Gordon, E.F. (2000). *Mockingbird years*. New York: Basic Books.

Hollowell, J. (1998). *Walk-in closet: Heart-felt poems*. Leawood, KS: Leathers Publishing.

- Jamison, K.R. (1995). *An unquiet mind: A memoir of moods and madness*. Vintage Books: New York.
- Kaysen, S. (1993). *Girl, interrupted*. New York: Vintage Books.
- Manning, M. (1994). *Undercurrents: A life beneath the surface*. San Francisco: HarperCollins.
- Mondimore, F.M. (1999). *Bipolar disorder: A guide for patients and families*. The Johns Hopkins University Press: Baltimore.
- Paterson, Judith. (1996). *Sweet mystery: A book of remembering*. New York: Farrar, Straus and Giroux.
- Schiller, L., & Bennett, A. (1994). *The quiet room: A journey out of the torment of madness*. New York: Warner Books.
- Slater, L. (1998). *Prozac diary*. New York: Penguin Books.
- Spaniol, L., Gagne, C., & Koehler, M. (Eds.). (1997). *Psychological and social aspects of psychiatric disability*. Boston: Boston University Center for Psychiatric Rehabilitation.
- Thompson, T. (1996). *The beast: A journey through depression*. New York: Plume.
- Wurtzel, Elizabeth. (1995). *Prozac nation: A memoir*. New York: Riverhead Books.

## APPENDIX I

### Document Analysis

As a secondary source of information, document analysis added depth to this study. Documents are rich sources of information that are “contextually relevant and grounded in the contexts they represent” and which “appear in the natural language of that setting” (Lincoln & Guba, 1985, p. 277). For the third interview, participants were asked to share short stories, journal entries, scrapbooks, photographs, newspaper and magazine articles, poetry, art, and song lyrics, or other materials that they felt captured their experiences living with a mood disorder.

Six participants shared materials for document analysis. Amanda, Jennifer, and Felicity forgot to bring materials to the third interview. After many attempts to contact them by phone and email after the final round of interviews, I was unsuccessful in my efforts to follow up and request information from them. The six participants who did bring items for document analysis were eager to share their materials and discuss the relation to their experiences living with a mood disorder. Document analysis was a fascinating experience which added depth to the study. Participants were able to uniquely express themselves and add a new dimension to their narratives through the sharing of materials that held personal meaning for them. Document analysis also provided an opportunity for the researcher to more deeply and intimately engage with participants.

*Alex*

Alex shared a poem given to her by a friend. The poem shared similarity in how she experiences her bipolar disorder, especially the lows of depression. She explained:



I liked the first part where it said, “I see her not dispirited, not weak” because that is how I wanted to think of myself that even though I was unhappy and depressed, that didn’t mean that I was weak, it just meant that I was battling something that was biologically out of control not spiritually or whatever. It’s just calling into mind that she has seen bad days before and she has seen darkness and she’s had good days, so she’s seen both, but the fact is that she kind of understands the cloudy days better because they are pretty deeply ingrained into who she is now and I guess being depressed and having those episodes in my life is a huge part of my life. My ups and my downs are both who I am but I guess I take into account my downs more often because I have to work on them harder than I have to work on being happy.

### *Billy*

Billy shared journal excerpts from his diary. He turns to writing as a tool to help him when he has “serious questions and problems.” Billy described journal writing in the following way:

It’s a window into my mind at the time. The purpose of a journal for me is mostly a place where I can bounce my ideas around and figure out what I actually feel because sometimes I don’t even know what I feel until I start writing. Usually, I have to be frustrated. The mood I guess that I have to be in is angry and that will make me want to do it. If I feel just down and sad, I wouldn’t do it then. Writing kind of just documents what was going on at the time. I feel like I would be able to look back at it later and have an idea of where I was. But I find that hard to do even now. I find it hard even when

I'm reading my journal now to remember what it was like to feel that way.

The journal is only useful when I'm out of the deepest part of my moods.

*David*

David shared a song by the band Depeche Mode and described its relation to his own life and experience living with bipolar disorder. He shared:

The song *Blasphemous Rumors* is about this girl who is 16 and she attempts suicide and she lives and on her 18<sup>th</sup> birthday she tries again and succeeds.

The song talks about her mother having to deal with her daughter committing suicide and the singers are saying how if there is God, then he is sick, as in masochistic, and so I'm kind of like that. I thought a lot about religion and theism and I'm personally agnostic and I just believe that if there is a God that it doesn't explain the paradox that there is a God who is supposed to be omnibenevolent, but at the same time this girl is so troubled and miserable that she kills herself. I feel like how can there be a God when so much pain happens . . . There is no way I can overstate how painful bipolar is . . . It's locked me up and kept me away from normal functioning and it causes a great deal of pain in my life . . . It's been just a very devastating experience. A very painful experience.

*June*

June shared several items for document analysis. First, she shared a personal writing piece – an essay she wrote for a course which focused on biographical writing. She entitled the piece *Distopian Future* which described her life projected in the future. She shared:

I wrote it and it's about me trying to be a writer and not writing anything and having this really impoverished life and really socially isolated life. And the feeling of frustration and non-existence was such a visceral thing for me to feel and write about. It's about depression in a coded way. There is nothing about depression in the piece. I didn't even think that as I wrote it, but after I read it, I was really scared. Whenever I think about fears for the future, they are all reflected in this one piece. The most important thing in life is connection – whether it's connection to your work or connection to other people – and my fear is not having that and not connecting. And I struggle with this all the time. So that is really reflective of me living with depression and it's interesting how unconscious and deep these feelings are that they come out when I didn't intend it to be.

June also shared two book excerpts which reflected her experiences with depression. June's self-selected pseudonym was inspired by a character in the first book she shared, *The Joy Luck Club* by Amy Tan which explores the relationships between Chinese women and their Chinese-American daughters. June shared the following:

The character June who inspired my pseudonym is relevant to me. She is this person who doesn't have anything going for her in terms of a specific achievement that she has made. The last scene is that they are at this dinner party that her mom had thrown . . . At the end, there is a scene with her mother and her mother tells her that she has her own style and her own self-worth. The way that it's written, it explains how I feel about the whole idea of

self-worth and what makes someone worth something and it's something that I struggle all the time and this is something that reminds me. June narrates the book and she is the one who hasn't done anything but she is the one who tells the story and that is the most powerful position to have. Whenever I feel depressed and have a bad view of myself, I go back to that scene.

The second book June shared was Susanna's Kaysen's *Girl Interrupted*, a memoir about Kaysen's psychiatric hospitalization and her experiences living with depression. June shared an excerpt from the book's chapter *Elementary Topography* and described its connection to her life. She said:

It talks about the year she [Kaysen] was in a mental institution when she was 18 and it's one of those books where she seems so normal and insane and plays with who is sane and insane. The one excerpt I have is from the Elementary Topography section and she is explaining why she attempted suicide and her whole explanation is that she sees this as a partial abortion – she just wanted to kill the part of herself that wanted to kill herself. Not that I'm suicidal or that I spend a lot of time being suicidal, but that is how it is for me – a desire to kill the diseased part of me, this illness in me, this part of me that I don't feel good about it. How do you get rid of that?

June also shared lyrics to two songs that were relevant to her experiences living with a mood disorder. First, she shared Fiona Apple's *Paper Bag*, a song that related to her romantic relationships. She shared:

The song is about her in the beginning of a relationship and she is really attracted to the person but is torn because she knows that she is crazy and she

doesn't know the fact that she is crazy means that she is incapable of love.

And also the person she is attracted to doesn't know how to handle her. There is this line and he said "it's all in your head" and I said "but so is everything and he didn't get it. I thought he was a man but he was just a little boy." I felt just that in my one relationship. I felt like I'm crazy and I can't be crazy with you and I identify with the song because of that experience where your craziness is this thing that is isolating and it's tricky in terms of romantic relationships.

June shared how the song *Between Bars* by Elliott Smith connected to her process of "making sense" of her mood disorder. She said:

The song lyrics stand out for me. The way the song is structured, he is talking to a girl and he tries to comfort her, and it's hard to explain, how I am drawn to the song. It speaks to my experiences with depression in complicated ways and it talks about "people you don't want around anymore" it's just one of those things that I don't want to be my depressed self. I discovered this song right around the time that I was trying to make sense of my depression in college and I wanted to separate myself from that and I didn't want to be that. Also, just not being able to see yourself for who you are. I identify with the person he is singing about.

### *Olivia*

Olivia is a studio art major and shared three self-portraits which reflected her mood at the time she created each piece. The first illustration was a self-portrait

Olivia created in Fall 2003. The following is Olivia's description of this self-portrait or study, as she referred to it. She shared:

I took these pictures of myself when I was upset one day and so I made references to this in how I painted my face. I painted it hot pink to represent how girls have to be pretty in pink and they put on this mask to look nice and be happy, but it's kind of an oxymoron in that it's hot pink, but the images of me crying, my face is cut up into pieces and it's not all together. And beneath it is how I feel sometimes, with the dripping blood and the wires and it's just really jagged and that is how I feel sometimes . . . This study was done when I was in more of a manic state. When I get manic, I get really fridgidity and I can't really keep still and so that is why they look like they have so much movement in the sketching of it.

Next, Olivia shared a self-portrait which depicted her mood during her depressive episodes. She said:

This is another self-portrait and it's based on the photos I took of myself when I was crying. I did this, I was a little depressed rather than manic and I guess you can see the difference, in that when I'm manic, I sketch more and I have to have more movement and this one is more just color base. It's watercolor and then after I was done, I decided to paint like a thin coat of red acrylic paint over it, I have this thing with blood, and so that is why I put the red over it.

Finally, Olivia shared a self-portrait that she created during a manic period. She described this piece as having more movement and use of lighter colors which reflected her mania. Olivia shared:

This is another self-portrait. I was pretty manic when I did it. And you can see the difference. This is all painted but still I added lines to it and there's a lot of space where I didn't even put paint on. I think I do better artwork when I'm manic just because there is more movement to it. And it's not so heavy because dark colors are very heavy on compositions so when you have a variety of lights and darks and contrasts, it makes it more dynamic and you can see more form.

X

X shared several books and discussed their relevance to his experience living with depression. He also described his tattoos and shared their significance to his life as a person with depression. His descriptions reflect the interconnections among his identities as a Black, gay male with depression. First, he shared how *Frankenstein* by Mary Shelley connected to his experiences living with these identities. He said:

My favorite book of all time has to be *Frankenstein*. There have been a lot of times when I was coming to grips with both my mental illness and my depression and being gay, I felt very angry at the world because I was like "Why me? Why did God do this to me? Why can't I just exist like everyone else?" And the same way, I always feel as though I've always been misunderstood, the same way that the Frankenstein monster was. People think that Frankenstein is the name of the monster, but it's not, it's the name

of the man who created him. The monster didn't even have a name; he was deprived of an identity even from his birth. And I feel as though having a mental illness and things that spoil my identity, I'm very much a monster just like he is. And in the movies, he is always portrayed as someone who can't articulate himself, but in the book, he is articulate, he has the mind of a scientist and he can read, he can write, he has all these emotions but he is not seen as a human being in part because he is so ugly. I felt the same way about my skin color, you know, people assuming that I was ugly and stupid.

Next, X discussed *Lady Chatterly's Lover* by D.H. Lawrence which illuminated what it means for him to live with depression:

*Lady Chatterly's Lover* talks about how this woman just feels trapped by her role in society and about how she feels about the roles that she can do. A part that captures what it means to have depression is in chapter 3, page 18 and it describes how Connie feels about her situation. Her husband has been paralyzed in WWI and so there is no intimacy in the relationship. And she just has restlessness inside of her . . . And when I was deep in depression, that is very much how I felt. There was just this restlessness, this anxiety, this uneasiness, and I was losing weight and was very much feeling trapped within these confines of society, not being able to express myself or being true to what and who I thought I was.

X also shared the book *Grendel* by John Gardner and described how the monster in the book represented his experiences with depression. He said:



It talks about how this monster, like when you're depressed, feels no joy about anything. He wakes up in the morning and hears the birds chirping and he looks up at the sky and he thinks about these stupid birds, these stupid people, looking at seasons that never were really meant to be observed. He is like oh, the absurdity of everything. Sometimes, when I was really depressed and I would think about things so much, I would get trapped by this feeling of anxiety and absurdity that nothing really meant anything, that what are we all doing here? Why am I doing this? Why am I going through the motions? I felt as though I was this artificial human being, this monster that was kind of in a paradox that even though I was not seen as a real human being, I was looking for things that were real like human connection, kindness, and these were things that when I was really sick that I felt like my life was completely void of.

Another book shared by X was Brian Aldiss's *Supertoys Last All Summer Long: And Other Stories of Future Time*. X related this book to the interconnections of his multiple identities as a Black, gay, man living with depression. He shared:

The book is about a robot boy, I think his name is David. And it was the inspiration for Steven Spielberg's movie AI. And it talks about a little boy named David that no matter what he does; he can't win the love of his mother because he is not real. And it connects to me because during my mental illness and a lot of my other identities, being gay, being Black, I felt that no matter what I could do, no matter what I would to make myself feel like an esteemable person, that I would never be loved, that I would never be seen as

a worthwhile or real person because of these identities. So that is why I identified with David because I felt kind of like a robot boy who was just waiting in line for somebody to love him, to make him real.

Finally, X shared Ralph Ellison's *The Invisible Man* and discussed how the book related to his struggles to establish his identity. He said:

Probably another one of my favorite books besides *Frankenstein* is *The Invisible Man* by Ralph Ellison and I remember before having to read that for class, the first paragraph is so eloquent that I committed it to memory. He says, "I'm an invisible man. No I'm not a spook like those who haunted Edgar Allan Poe, nor am I one of your high looboctoplasms. I am a man of substance, of fiber and gold, flesh and liquids. I might even be said to possess a mind. I am invisible simply because people refuse to see me. Like the bodiless head you sometimes see in circus sideshows, it is though I am surrounded by mirrors of hardest stone glass while onlookers seeing themselves my surroundings are different from their imaginations. Indeed, everything and anything except me." At times when you disclose your illness, you feel everybody sees that part of your identity except you. So you might as well be invisible . . . It speaks to me because at times I feel as though my illness, my race, or my sexuality have been the defining part of my identity and made everything else about me irrelevant. So therefore making me invisible . . . I connect it to depression in the fact that when I tell someone that I have clinical depression, I no longer become X, I become someone who has depression. It's something that becomes what in sociology we call a master

status. It completely corrupts your identity and it's all they see - the illness instead of you as an individual.

X also shared that he has tattoos which are significant to him and hold meaning for his experiences living with depression. He said:

I've gotten to a point with my mental illness and my disclosure that I have them tattooed all over my body. I have 8 tattoos and they all have a special significance. I have three on my left arm, two on my right and one on my chest and one on my back and they all have a special significance linking to my mental illness as well as my various social identities . . . Everything about my life I always link to something else. And these tattoos are just metaphors about how I feel about myself as an individual at times in my life and how I feel I'm related to as an individual within society and reminders to me about how I should conduct myself and not to forget all the lessons I've learned. Because I think you can get to a place where you're like "well, you know, I've dealt with this" and you kind of forget all the lessons you've learned and you just go back to doing the things that you used to. So I wanted a physical reminder of all the things that I've gone through.

X provided descriptions of each tattoo and its meaning. His accounts are provided below.

This one, in Hebrew it means "Golem." It's a Jewish word. It means "anything good in life by a magic spell." In the 16<sup>th</sup> century, a Rabbi created a golem out of clay and he shaped a man out of clay to protect the Jews in the Prague who were being crucified because they said that the Jews were killing

babies and mixing their blood with unleavened bread and wine. So I link that again to my mental illness because I feel as though at times, my mental illness has robbed me of the emotions to feel human. I felt like a clay person and also being brown, I thought it's just a metaphor about how I think society sees me as not a real person but a person made out of mud.

I have Chinese characters on my arms that mean "lonely" and "heartbroken." Because I think I was lonely and heartbroken ever since I was born and throughout my illness, I felt that way. And it links to my golem tattoo to remind me that to a degree I still am lonely and heartbroken and I think I will always be that way to some degree, and also to remind me to help the people who are because the golem was a protector. So it reminds me to link it to protect people who are lonely and heartbroken and to protect people who can't protect themselves.

I have dragons, which are the same metaphor. Dragons in Chinese literature are a symbol of luck so I got them for luck. But also in Anglo-Saxon mythology, they were demons that were evil and mean and were persecuted by people but like the Grendel, being a human being, I think it probably was the other way around - that human beings were probably the persecutors, you know hunting these beasts because they looked different. So again, it's a reminder to respect things that look different and that a lot of the fear and

misunderstanding usually come from things that are misunderstood. And to remind me to try and understand something before I condemn it.

Appendix J  
Emergent Categories

CORE CATEGORY:

*Lifting the Veil*

Self-Disclosure Decision Making Process  
Self-Disclosure

KEY CATEGORIES:

*Receiving Diagnosis*

Reaction  
Type of Disorder  
Coming to Terms

*Constructing an Illness Identity*

Definition  
Orientation  
Living with the Disorder

*Impact of Stigma*

*Perceived Campus Support*

Faculty  
Staff  
Mental Health Services  
Peers

*Attributes of Personality*

Amanda  
Alex  
Billy  
David  
Felicity  
Jennifer  
June  
Olivia  
X

Appendix K  
Inquiry Auditor Letter



UNIVERSITY OF  
MARYLAND  
CAMPUS RECREATION SERVICES

1115 Campus Recreation Center  
College Park, Maryland 20742  
301.226.4400 TEL 301.226.4455 FAX  
301.226.4431 TTY

May 28, 2004

Partamin Farzad Nawabi  
4661 Weston Place  
Olney, MD 20832

Dear Partamin,

After reviewing the grounded theory model and explanation derived from the results of your study, I can attest that the core category, key categories, and the relationships among them are grounded in the voices of your participants as shared through their narratives. Your theory represents a complex phenomenon. Your participants provided you with complex data and you have done an exacting job of analyzing this data and developing a theory that accurately represents the experience of your participants. Your contribution to the literature regarding students dealing with mood disorders is an important one: increasing visibility to a largely invisible campus constituency.

Sincerely,

A handwritten signature in black ink that reads "Wallace Eddy".

Wallace Eddy  
Doctoral Candidate, Department  
Counseling and Personnel Services  
Assistant to the Director  
Campus Recreation Services

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